The Modern Hospital

APRIL 1953

Osteopaths and the Hospital System • Reorganization of Federal Health and Welfare Services • Symposium on Malpractice Insurance • Nursing Job Analysis • How to Train Supervisors • Modernization Project • Portion Control of Foods • New "Bedlifter"

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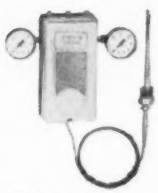
D-251
Piston Damper Operator

V-152 Water Valve for Air-Conditioning Units

T-271 Heating-Cooling Thermostat for Air Conditioning Units



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AMONG THE AUTHORS


Paul J. Gordon

Paul J. Gordon is assistant professor at the New York State School of Industrial and Labor Relations at Cornell University. His article in this magazine (*p.* 71) is based on a study in three central New York hospitals. The principal emphasis of the study was on organization relationships, administrative problems, and personnel administration. In the last three years, Prof. Gordon has conducted or taught in a number of hospital conferences sponsored by the school in cooperation with the American Hospital Association and the Central New York Regional Hospital Council. His previous employment includes five years with the Standard Oil (N.J.) in wage and salary, employment, and training assignments, in the United States and South America, and two years in the department store field. Prof. Gordon holds a bachelor's degree in business administration from the College of the City of New York and a master's degree in business administration from Cornell, and he is now completing additional work at the Maxwell Graduate School at Syracuse University.

Janette C. Carlsen, author of the article on food portion control on page 120, is dietitian in charge at the Johns Hopkins Hospital, Baltimore. Miss Carlsen is a graduate of Kansas State College, Manhattan, and has a master's degree in public health from the Johns Hopkins School of Hygiene and Public Health. After serving her dietetic internship at Johns Hopkins, she became an instructor in clinical nutrition at the school of nursing there and has been successively, dietitian in charge of ward service at Johns Hopkins Hospital and, since 1947, dietitian in charge.


Louis C. Brown

Louis C. Brown is administrator of the Hamilton County Public Hospital at Webster City, Iowa, a position he has held for the last two years. Mr. Brown is a graduate of the hospital administration course, Washington University, St. Louis. He served his administrative residency at the State University of Iowa Hospital, Iowa City. Before serving with the U.S. Navy in World War II, Mr. Brown was a member of the staff in the business department of Doctors Hospital, Washington, D.C. His article on the situation confronting county hospitals in Iowa and other states where the law prohibits discrimination against licensed practitioners of any "recognized school" appears on page 51.

Authors also appearing this month are **Joseph Lane** of St. Paul's Hospital, Dallas, who presents a report on fire safety (*p.* 82); **Mrs. Emily Stebbins** of the Evanston Hospital public relations department, with a program given by grade school children (*p.* 62); **Dr. David Littauer,** executive director of the Jewish Hospital of St. Louis, and **Gordon E. Soncrant,** director, Hancock County Memorial Hospital, Britt, Iowa, on consolidating professional service reports (*p.* 68). **Dr. Charles F. Wilinsky,** executive director of Beth Israel in Boston, and **Sidney Liswood,** assistant director, present the health center concept of coordinating preventive and curative medicine (*p.* 85), and **Frederick E. Markus** of the Boston engineering firm of Markus and Nocka continues the series of time and motion studies in the operating suite.

Roving Reporter

Forest Glen Rebuilds War-Torn Bodies

One of the army's unique installations celebrated its tenth birthday late in January. It is Walter Reed Army Medical Center's secluded suburban annex at Forest Glen, Md.

When the first World War II casualties were beginning to filter back to Walter Reed Army Hospital, the army purchased the 185 acre site occupied by National Park College, a private school for wealthy young ladies.

For its 1943 opening, the army transformed the 70 college buildings of varied architecture into the nucleus of a convalescent hospital for its ambulatory patients. By doing this the army freed bed space at its Washington section for patients needing constant medical attention.

The natural beauty of Forest Glen, its rolling hills, woods, streams, quiet surroundings, and Old World atmosphere combine to provide an ideal environment for rebuilding war shattered nerves and bodies.

Vast improvement and reorganization during the past few years under the command of Maj. Gen. Paul H. Streit, commanding general of Walter Reed Army Medical Center, has turned this installation into much more than a convalescent hospital. It now has all the services found in a small community.

Here are found a reorganized ambulatory section, stressing occupational therapy, physical therapy, and physical reconditioning of army and air force patients; the army's first school for the training of practical nurses; the audiology and speech correction center, the only military medical installation of its kind in the world, and the prosthetics research laboratory.

At the audiology and speech correction center patients are tested for extent of hearing loss, are fitted with the latest hearing devices available, and are given aural rehabilitation. Those with speech difficulties are taught to speak again. The center has a fully equipped laboratory for fabricating hearing and ear inserts.

Workers at the prosthetics research laboratory are engaged in fundamental research and the development and testing of prosthetics devices. Among achievements credited to the laboratory are the development of a mechanical hand which achieves from 40 to 60 per cent of the efficiency of a human hand; a cosmetic glove to be worn over the mechanical hand that is tinted to match the individual's skin tones and is noted for its amazingly lifelike appearance, and the voluntary closing hook, which provides arm amputees with a greater degree of versatility.

The architecture of Forest Glen is little short of amazing. The main building, dating back to 1890, was once a luxurious hotel named "Ye Forest Inn." Typical of the ornate magnificence of the period, it has a three-tiered ballroom with stained glass windows and an open beamed roof 70 feet above the floor. The Red Cross now uses the ballroom as a recreation lounge for patients. A

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hand-carved cherry fireplace mantel in the main entrance hall and a mirror, which covers an entire wall from ceiling to floor, came from the White House during President Theodore Roosevelt's term of office.

Small buildings—formerly sorority houses—are used as officers' quarters. The buildings range in architectural design from Chinese pagoda to Swiss chalet or Spanish mission.

Winding walks, bordered with boxwood and holly, twist between the buildings. The white Grecian columns of the gymnasium and the turrets, towers and archways lend the charm of old Europe to the surroundings. A 750 year old Italian fountain, which once adorned the palace of a Venetian prince, adds beauty to the administration building entrance.

A set of musical chimes, which cost the seminary around $12,000, is played every Sunday from the bell tower in front of the main building.

Construction of several new buildings is contemplated for use by the army medical service graduate school, another component of Walter Reed Army Medical Center. The buildings will be placed in an isolated section of Forest Glen and will further enhance the research and training work that is being done by the army's only graduate school for doctors, veterinarians and dentists.

Hospitals Get Out the Vote

Eisenhower & Others are attempting to carry out the promises made in last year's elections. Meantime in several state legislatures a bill lies in committee that would provide absentee ballots for hospital patients and other ill and physically disabled persons unable to cast their votes in person.

Missouri is believed to be the first state in the Union to have passed such a bill, and in last fall's elections the St. Louis Blue Cross Plan put on a campaign to encourage hospital voting. In this campaign the Blue Cross won the support of St. Louis hospitals and other outlying hospitals served by the St. Louis plan.

The chief device was a tray card furnished by the Blue Cross, informing each patient of voting age that he could vote and to ask his nurse for details.

Upon request, the patient was given a special form to fill out requesting an official ballot. This form was prepared by Blue Cross with the approval of the local board of election commissioners and was declared standard and legal for all of Missouri. The form had to be signed by the patient's physician, who gave the reason the person would be unable to vote at his regular polling place.

It was the hospitals' job to send requests for ballot forms to the proper election office, which, in turn, sent an absentee ballot for each patient requesting one. The ballot had to be signed in the presence of a notary public. Each hospital had several notaries and one would be sent to the patient's bedside to witness the ballot. Notarized ballots were then sent back to the election office and were counted in the general election. Several thousand votes were thus added to the Missouri total. Both hospitals and Blue Cross considered they had done a good public relations job by encouraging patients to vote.

The Blue Cross also ran a simultaneous campaign to encourage persons who knew they would be hospitalized at election time, such as maternity patients, to go to their local election office and vote. St. Louis

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newspapers cooperated in this campaign.

Other hospitals or Blue Cross plans may wish to copy the Missouri tactics when absentee ballots for the ill are legalized in their own states.

Their Goal Is 1,000,000

When you hear teen-agers lumped together as hot-rod drivers, vandals and throwers of beer parties, turn the attention of their adult critics to the high school students of Woodruff, Wis. There are only 130 of them in this town of 4000 in the northern part of the state.

Last November 1 in Teacher Otto Burich's geometry class at Arbor Vitae-Woodruff High School the students were discussing money raising stunts, and the young people decided to put on a drive for 1,000,000 pennies with the new Lakeland Memorial Hospital in Woodruff as the benefaction.

Their ambitious project won headlines and now pennies are coming in in packages and jars from everywhere in America and abroad.

Checks also have arrived from 38 states and from 11 foreign countries. By the end of February the students had 700,000 pennies. Excitement is mounting with the pennies.

The students hope to reach their goal by Memorial Day. If so, the new hospital will be the richer by $10,000. Construction is going on at present.

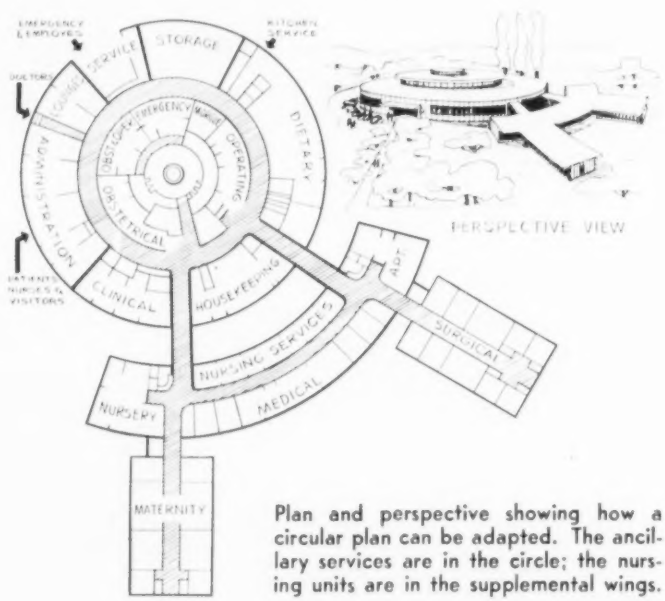
Reader Opinion

Circular Plan

Sirs:

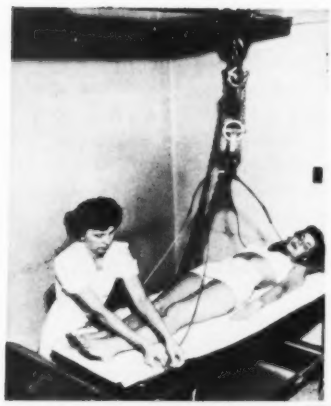
I was very interested in the article regarding the circular hospital plan shown on page 51 of your August 1952 issue. I am herewith enclosing two sets of photostat copies of a series of studies that our office completed which showed the feasibility, from a planning angle, for the construction of a hospital on the circular plan. You will note that we found it more workable and economical to limit the circular form for the ancillary facilities and a supplemental form, portions of which are rectangular, for the nursing units.

Russell G. deLappe & Associates
Berkeley, Calif.



Plan and perspective showing how a circular plan can be adapted. The ancillary services are in the circle; the nursing units are in the supplemental wings.

Cleaned in a Few Minutes...READY FOR NEXT PATIENT



Blickman stainless steel equipment with seamless, round-corner construction, speeds service in Hydrotherapy Department

• This stainless steel underwater treatment tank can be thoroughly cleaned and made ready for the next patient in a matter of minutes. All surfaces are smooth and continuous. There are no seams, crevices or joints of any kind. The highly polished stainless steel reduces adhesion of dirt and grime. Cleaning takes far less time and effort, because all corners and intersections are fully rounded. Complete asepsis is attained with a minimum of labor. This means that you save money every day you use this long-lasting unit. That's why so many leading hospitals have standardized upon Blickman-Built hydrotherapy and physiotherapy equipment in sanitary stainless steel. We invite you, too, to *investigate and compare*, before you buy.

ABBOTT Model I-Beam Hoist of all stainless steel remains free of rust and corrosion, no matter how much hot, moist steam arises from the hyrotherapy tank.

HOT SPRINGS Model Underwater Treatment Tank—as used in St. Mary's Hospital, E. St. Louis, Ill. Designed for ready access to all parts of patient's body. After each treatment, tank is drained, scrubbed and brushed with surgical soap. Cleaning is easy because of the polished stainless steel surfaces and the round-corner construction. Aerators circulate water through pressure action, not by electrical means. Danger of shock is eliminated.

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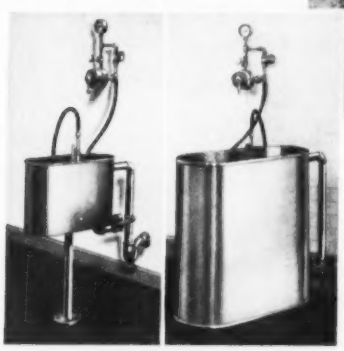

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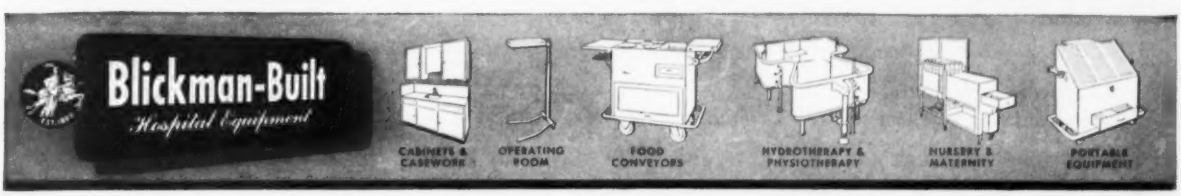

You are welcome to our exhibit at the Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N. J., Booths No. 101, 103, May 20-22, and to the Catholic Hospital Association Convention, Kansas City, Missouri, Booths No. 701, 703, May 25-28.

That January Issue

Sirs:

The editorial on the televised show from Denver (January 1953) is lovely in its simplicity and truth.

The round table discussion on "Doctors Will Help You Cut Costs" bears directly on a subject I have very much in mind—an old subject with brand new meaning: integration. Everything I know and think makes me feel that only through the integration of ideas and opinions and experiences can doctors, administrators, nurses, et al, meet the demands of today. Everett Jones says, "the newer generation of doctors is looking less and less upon nurses as their servants and is treating them more like teammates." Yea, verily. It's why I'm working my fool head off, trying to make nurses realize *their* responsibility in developing new attitudes and new ways of sharing. I cannot reconcile "integration" and "signed contracts."

Dr. Hawley's brave, diplomatic piece on the accreditation program deserves honorable mention, too. I'll pay for Dr. Crosby's lunch if he will give me a bit of time to teach me more about that program. It seems to have real promise. I want to know where nursing comes in on it.

There's another article I like very much: Sister Mary Anthony's on teaching students. She's really out to develop *nurses*—nurses who know what sick people are like, what it takes to help them get and keep well, nurses who know how to work with others with a vested interest, too, in patients. I'm so fed up with lofty, nose-in-the-air efforts in some quarters to develop super-nurses who will nurse "through" others, that this kind of straight, sound, fair teaching goes to my heart as well as my head. Sister Mary Anthony plays so fair with the students! And in the end that means playing fair with the patients.

Janet M. Geister, R.N.
Chicago

Storm Over Danbury

Sirs:

Troubles at Great Neck and Danbury prove to me that much trouble and real heartaches would be eliminated in this and other fields if people would sit down and talk to each other. The joint conference committee of the board of trustees and the medical staff is part of the answer toward solving tensions between these groups in the hospital. We schedule our meetings here a year ahead. Too many times intentions to have meetings are never realized and it gets to be too late.

The story "Storm over Danbury" is classy reporting. Will this be printed in pamphlet form? There are many powerful lessons in this.

Hal G. Perrin
Bishop Clarkson Memorial Hospital
Omaha, Neb.

Inimical or Constructive?

Sirs:

I have read the most interesting article, "Storm Over Danbury," in the February issue of The MODERN HOSPITAL and my reaction is that it is inimical to the public welfare rather than constructive.

Promotion by all concerned in every possible way of the acceptance of responsibility by our governing boards for the quality of professional care in our hospitals will, in my opinion, prove of great benefit to those who use them. It appears that the subject article is biased and may have the opposite effect.

C. D. Jeffries
Oak Ridge Hospital
Oak Ridge, Tenn.

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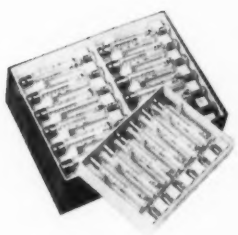

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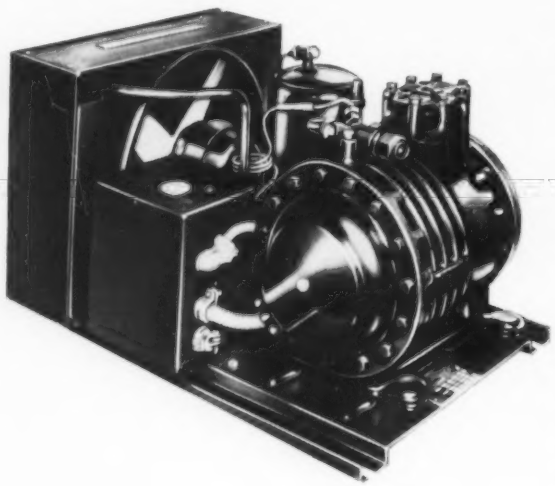
Takes less floor space than conventional compressors of comparable capacity. Lighter weight combined with resilient mountings allow greater flexibility in installation.



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Direct-drive, refrigerant-cooled motor, special bearings, pressure lubrication, guarantee day-in, day-out dependability.

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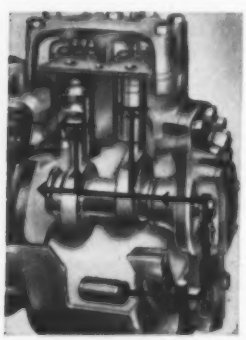

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Here's the sensational new Frigidaire Compressor that's built to keep trouble away . . . built to banish the causes of 70% of all compressor service calls. Direct drive eliminates fly-wheels, motors, pulleys, compressor belts, and shaft seals. It's sealed against moisture, dirt, dust, and air; yet *all* parts are fully accessible for inspection and maintenance.

Here's why XD means Extra Duty! Full-rated capacities assure delivery of full cold-making power. Extra dependability with filtered oil delivered under pressure to every bearing surface. Extra motor life with windings cooled by refrigerant gas to operate at much lower temperatures. Available in air cooled models, ⅓ to 3 hp, water cooled models, ½ to 7½ hp. Call your Frigidaire Distributor or Factory Branch Office—his name is in the Yellow Pages of your phone book. Or write Frigidaire Division of General Motors, Dayton 1, Ohio. In Canada, Toronto 13, Ontario.

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The most complete line of air conditioning and refrigerating products in the industry

Build Goodwill
Build Profit too!

HOLLISTER *Custom-Made* Birth Announcements

Sell only 300 Boxes—
make at least $217 profit

It's easy to build goodwill for your hospital and show a handsome profit at the same time. Just offer new Hollister *Custom-Made* Birth Announcements to your maternity patients—see how eagerly they buy, how much they will appreciate the service and your thoughtfulness.

You sell Hollister Announcements to parents for just $1.85 for a box of 12, your profit per box is generous and we furnish ample selling helps. For example, you need sell only 300 boxes to realize upwards of $217 (depending on the quantity you order).

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Write today for samples and complete details of how you can make a substantial profit with Hollister *"Custom-Made* for you" Birth Announcements. Send the convenient coupon below right away.

Featuring a clever miniature
of your hospital's actual birth certificate

8 delightful baby-design covers
in each box of 12

Please send me: (check)

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(Please fill in name and address on reverse side)

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YOURS? *of course I'm yours!*

see my **Ident-A-Band®**

PATENT APPLIED FOR

Unalterable — correlated

Mother-Baby Identification

positive **with the Ident-A-Band**

THERE'S never, ever a doubt in mother's mind when you use the Hollister pre-numbered Ident-A-Band system in your delivery room. She is always sure, because she can tell from the identical numbers, that the band sealed on baby's wrist is actually a part of the very same Ident-A-Band sealed on her own wrist.

She is even further assured because she can see full information about her baby right on the insert card also sealed in the band. She knows as well that the numbers, preprinted inside the band, can never be changed, can never be duplicated, are an integral part of the band itself.

She knows too that the soft, non-irritating Vinylite Ident-A-Band, once sealed on her wrist and on baby's wrist in the delivery room, can never be used again, and will never come off unless cut or torn with obvious force.

Offer the mothers in your hospital the assurance of this new modern system. You'll find it provides the complete, unalterable correlated identification system as recommended by the American Hospital Association.

Get the details for yourself today. Mail the coupon below for a sample band, complete information and prices.

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INDEX TO ADVERTISEMENTS

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NOW AVAILABLE FOR CIVILIAN USE

Expandex®

(DEXTRAN) Injection 6%

an efficient

plasma volume expander

for use in the treatment of SHOCK

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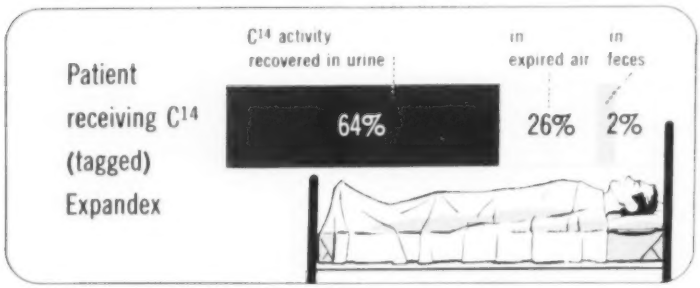
Expandex®

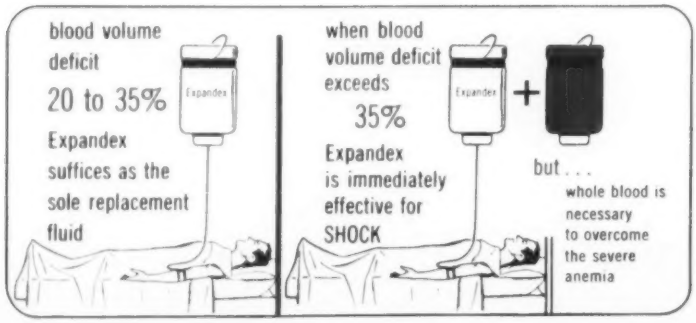
(DEXTRAN) Injection 6%

an efficient means of expanding circulating plasma volume

in the treatment of Shock due to Hemorrhage, Burns, Trauma and Surgery

These laboratory and clinical findings establish **Expandex** as an efficient, safe, effective plasma volume expander





Chemistry

Expandex (Dextran) Injection, 6% is a sterile, nonpyrogenic 6% (w/v) solution of partially hydrolyzed dextran in isotonic sodium chloride solution. Dextran itself is a water soluble, high molecular weight polymer of glucose, which is produced by the action of the nonpathogenic organism *Leuconostoc mesenteroides* on sucrose. Dextran is closely related to glycogen; both these polysaccharides are made up of glucose units joined by similar linkages.

Pharmacology

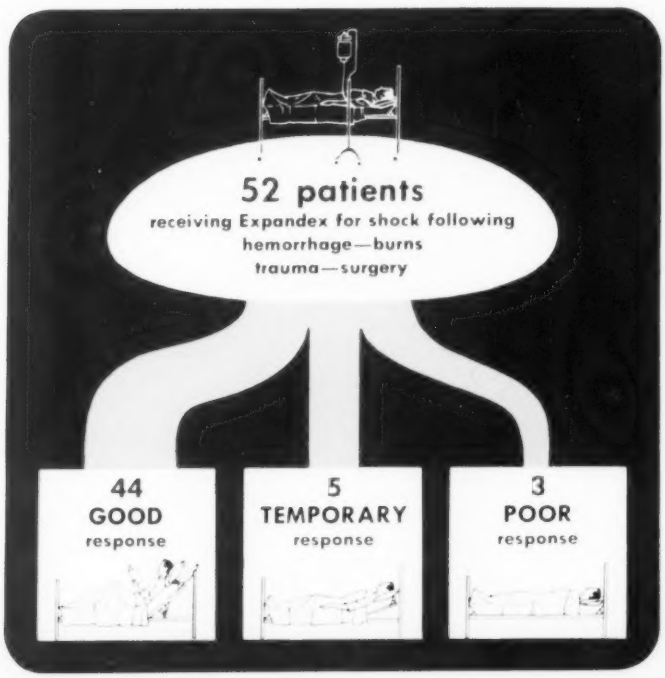
Given by intravenous infusion, Expandex is an efficient plasma volume expander.[1] As such it produces hemodilution manifested by a decrease in hematocrit and in total protein concentration. A 10% to 15% increase in plasma volume is produced by an infusion of 500 cc. of Expandex, while a 15% to 20% increase is produced by 1,000 cc. In normal individuals, Expandex has no influence on pulse rate, respiration, blood pressure, or ECG. No toxic effect has ever been demonstrated on kidneys, liver, and other vital organs.[2,3,4] Expandex does not interfere with blood typing, crossmatching, or Rh determination.

Fate

Virtually all injected Expandex can be accounted for through the experimental use of C^{14}-tagged dextran.[5,6,7] From 20% to 40% is excreted in the urine in the first 24 hours; the total urinary excretion of C^{14} activity is 65 to 75%. The bulk of the remaining radioactivity is recoverable in the expired air, indicating metabolism of dextran by the organism. About 2% is found in the feces.

Clinical Results

Expandex has been used with excellent results in all types of shock associated with a decrease in effective circulatory volume.[8,9] The plasma volume expansion it produces is maintained for periods sufficiently long to enable the circulatory system to overcome the altered dynamic state. In a typical series,[10] 52 patients in shock were given Expandex. Of these, 44 showed a good response, 5 a temporary response, and only 3 a poor response. Since it is sterile, Expandex does not carry, nor can it transmit, the virus of infectious hepatitis.



Indications and Dosage

Expandex is indicated in the treatment of shock caused by hemorrhage, burns, trauma and surgery. It can serve as the sole replacement fluid in hemorrhage when the blood deficit does not exceed 35%.[10]

Expandex is given by intravenous infusion; the average dose is 1 or 2 units (500 cc. or 1,000 cc.). A larger quantity safely may be given if required.

Clinical Advantages of Expandex®

1. It is a clinically effective and notably safe plasma volume expander, indicated in the prevention and treatment of shock due to hemorrhage, burns, trauma and surgery.
2. It is slowly metabolized and excreted.
3. It does not carry and therefore cannot transmit the virus of hepatitis.
4. It does not interfere with the functional activity of any organ or tissue in the body.
5. It does not interfere with blood typing procedures or crossmatching.
6. It is a nonpyrogenic and sterile solution.
7. It is fluid over a wide range of temperatures and is ready for immediate use.

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First to produce crystalline penicillin in commercial quantities

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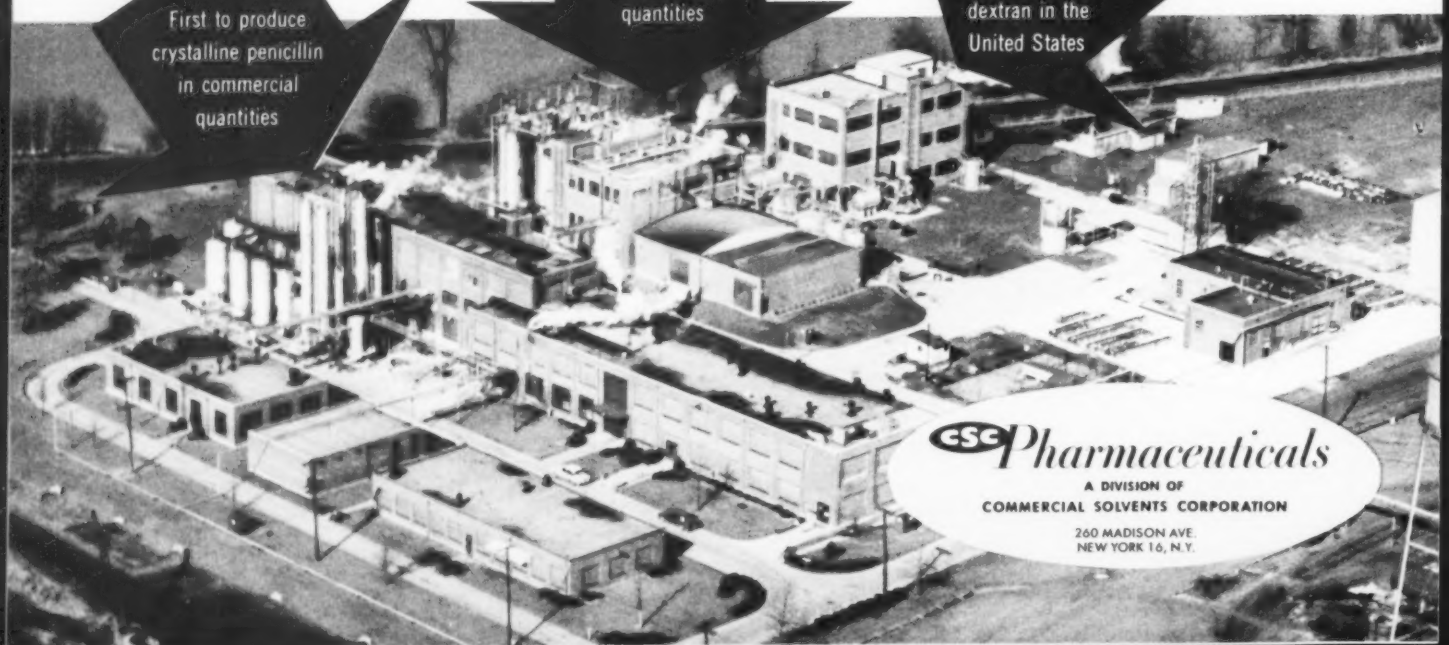

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Dispensa-cart

Reduces medicine dispensing to simple routine

One trip service by one nurse

30 oral medications 20 hypodermics

Safe, card-in-slot identification

. . . a truly sensational contribution to nursing efficiency

The new Aloe Dispensa-cart makes possible a definite, yet flexible, medicine dispensing routine that eliminates objections commonly noted in the usual medicine cart. An oral medicine rack mounted on the top has a capacity of 30 medicine glasses or paper cups, yet there is generous work surface remaining. Two removable hypodermic syringe trays hold 20 syringes in individual clips completely free from contact. Attached to posts of the frame are three receptacles mounted to swing out as needed: a stainless steel tray for discarded syringes, stainless steel cotton reservoir, and waste receptacle, interchangeable to suit your technic. A convenient shelf provides ample space for water pitcher and extra supplies.

Thus, after complete preliminary preparation of medication, with every dose identified by a card imprinted with name, room, medication, dosage and time, the nurse is ready to accomplish work in a single round that would ordinarily occupy the time of several nurses for a much longer period.

The Dispensa-cart has many incidental conveniences that speed up the nurses' work: flashlight, to provide light for quiet, bedside use; recessed ball-bearing swivel casters permit normal stride, pushing or pulling; full width handles with rubber bumpers. When you install this efficient system, you'll be amazed at the saving in nurses' time alone.

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Transparent . . . for general office use and certain surgical applications.

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Made with a woven elastic backcloth . . . molds to the body for desired support . . . extremely comfortable.

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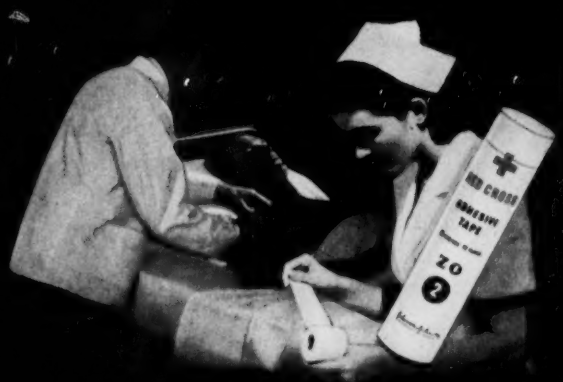
A liquid adhesive . . . for affixing small dressings in difficult-to-bandage areas.

WATERPROOF **ADHESIVE TAPE**

Made with an embossed waterproof backing . . . available in "Cut-Quick"* dispenser or hospital rack rolls.



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Finest tape available . . . recommended where unusually high tensile strength is required.

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BAND-AID* MOLESKIN **ADHESIVE**

A thick, soft, napped backcloth mounted on crinoline . . . for padding and cushioning.

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Replaces both gauze and adhesive at low cost . . . sticks only to itself — not to hair or skin . . . water- and oil-resistant.

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Thin, elastic . . . conforms to body contours and movements; washable, grease- and oil-resistant.

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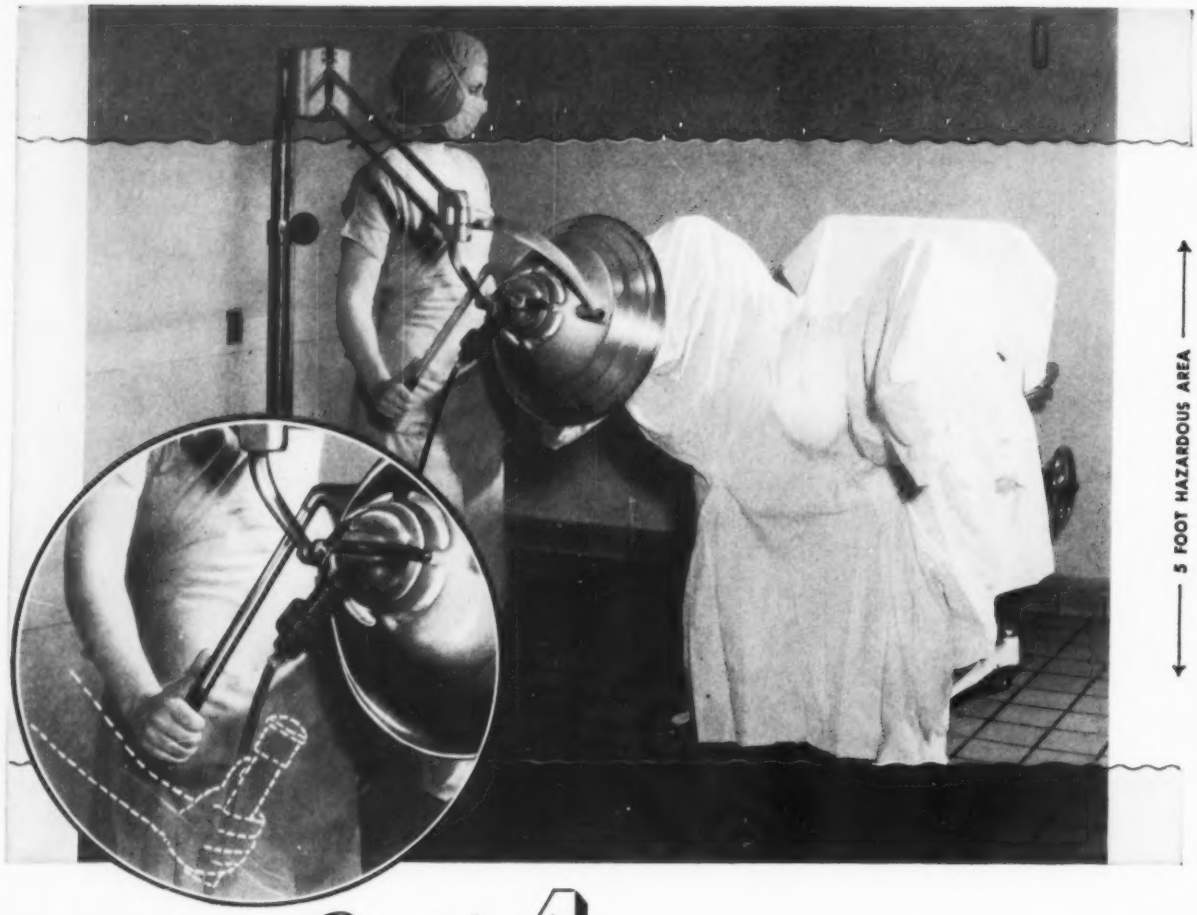

Demand *Castle* 4-star performance

FINGER-TIP CONTROL — The beam of the Safelight is positioned with the speed and facility of a flashlight in the hand. In its three most popular models, there is no counter-weight, no heavy ball to cause exasperating head injuries. Its internal counterbalancing mechanism is smooth, effortless, and uses no functional devices or manual locks. (Note: No. 51 does have counterweight.)

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FOUR 4-STAR MODELS — The most popular Safelight model is the No. 52, floor type with pantograph arm . . . available with 4-footed or circular base. The Wall and Ceiling types, Nos. 53 and 54, also feature the "easy-as-pointing-a-flashlight" adjustability. An alternate floor model, No. 51, has a conventional ball counterweight. Floor model casters are static conductive and provide complete stability in all lamphead adjustments.

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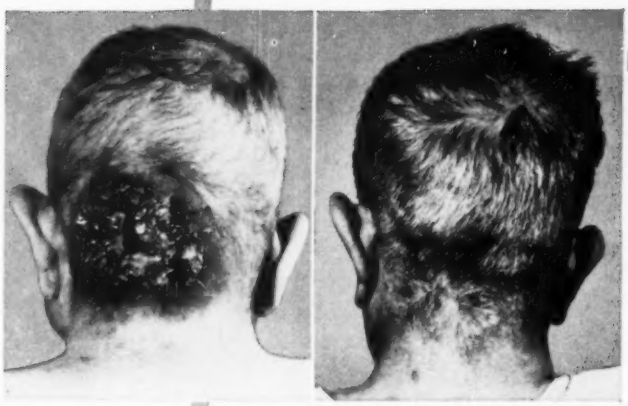

Carbuncle . . .
particularly amenable to
Tryptar debridement

Tryptar

is also effective in burns, soft tissue abscesses, osteomyelitis, fistulae, sinus tracts, and varicose ulcers.

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WITHIN HOURS

Tryptar dissolves necrotic tissue, surface coagula, clotted blood, purulent secretions and fibrinous strands by physiologic enzymatic action. So rapid is debridement on external lesions that excellent clearing may be obtained within hours. Tryptar acts with complete safety because it cannot digest viable cells nor connective tissue. Neither sensitivity nor antigenicity has been reported from the use of Tryptar.

Also available as Tryptar Aerosol for introduction into the respiratory tract. Clogging purulent bronchial secretions are rapidly liquefied and can be easily expectorated.

For detailed information write to Medical Consultant Service, The Armour Laboratories, 520 North Michigan Avenue, Chicago 11, Illinois.

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

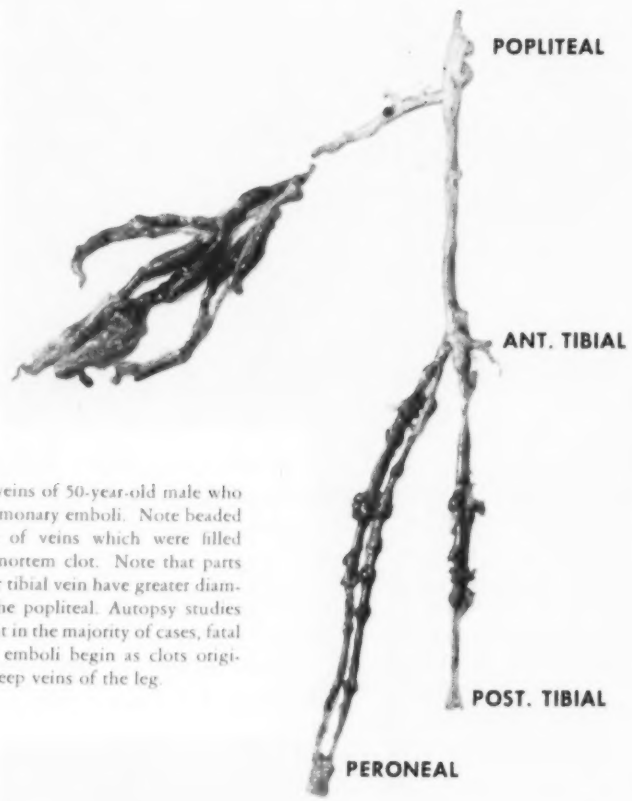
The *new* leg compression prophylaxis of pulmonary embolism

New hospital routine uses elastic stockings as safeguard against fatal embolism

Pulmonary embolism ranks with tuberculosis as a cause of death. Embolic deaths are up 56% in 15 years—and the dominant causative factor is circulatory stasis accompanying bed rest.

That is why you will be interested in the new hospital routine that prevents embolism in its most common point of origin—in the deep calf veins of the leg.

The new routine calls for the wearing of a special type of inexpensive elastic stockings by all bed patients *as standard procedure*. These stockings, the new T. E. D. Elastic Stockings developed exclusively for this purpose by Bauer & Black in cooperation with Massachusetts Memorial Hospitals, exert just enough pressure to speed blood flow through the deep leg veins and minimize clot propagation.



Deep calf veins of 50-year-old male who died of pulmonary emboli. Note beaded appearance of veins which were filled with ante-mortem clot. Note that parts of posterior tibial vein have greater diameter than the popliteal. Autopsy studies indicate that in the majority of cases, fatal pulmonary emboli begin as clots originating in deep veins of the leg.

Specimen photograph courtesy of Joseph R. Stanton, M.D., Massachusetts Memorial Hospitals and Boston University School of Medicine.

In tests, Massachusetts Memorial Hospitals divided patients into two groups. A group of 2,346 patients wearing elastic stockings suffered no deaths from embolism although there were 2 non-fatal cases. In a similar group *not* wearing elastic stockings four persons died of embolism and there were 12 non-fatal cases. Continuing studies indicate further encouraging results.

You are invited to study the life-saving possibilities of the new leg-compression routine in your hospital. Write to Bauer & Black Research Laboratories, 309 W. Jackson Blvd., Chicago 6, Illinois, for an illustrated report on current pulmonary embolism studies.

*Reg. U. S. Pat. Off.

T. E. D.*
ELASTIC STOCKINGS

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Division of The Kendall Co.
309 West Jackson Blvd., Chicago 6, Ill.

ENDS SCUFFED-UP FLOORS!

Now from Johnson's Wax comes the toughest, longest-wearing self-polishing floor finish ever developed.

New Heavy Duty *Hard-Gloss* dries to a finish so bright . . . so hard that it ends scuffed-up floors. Even heavy foot traffic in busy corridors and public passageways won't scuff it up. One application stands up under *wear* and *water* far longer than ordinary self-polishing waxes. No need to buff . . . *ever!*

Ordinary polishes are soft. Each footstep tends to push the polish into tiny ridges, creating scuff marks. The result: unsightly floors . . . frequent buffing.

New Heavy Duty Hard-Gloss stays anchored firm and smooth. Its exceptional scuff-resistance makes floor maintenance far easier . . . far less costly.

Water won't dull the shine!

Here at last is a floor finish that can take repeated damp moppings! Hard-Gloss's tough shine will even stand up under tracked-in rain and snow around public entrances. Ends water-spotting around drinking fountains.

Makes floors extra safe!

All types of flooring take on *extra* safety with Heavy Duty *Hard-Gloss.* It is *not* tacky, *not* gritty. Yet Hard-Gloss has greater traction than most "anti-slip" finishes.

Easy to remove!

Durable as *Hard-Gloss* is, it can easily be removed with Johnson's *Floor Cleaner* or Johnson's *Emerel.* No hard scrubbing needed.

Let us prove on your own floors the greater protection . . . beauty . . . economy of Heavy Duty Hard-Gloss.

Write today for FREE demonstration.

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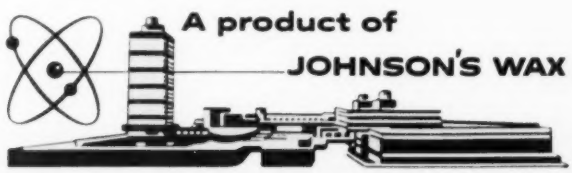

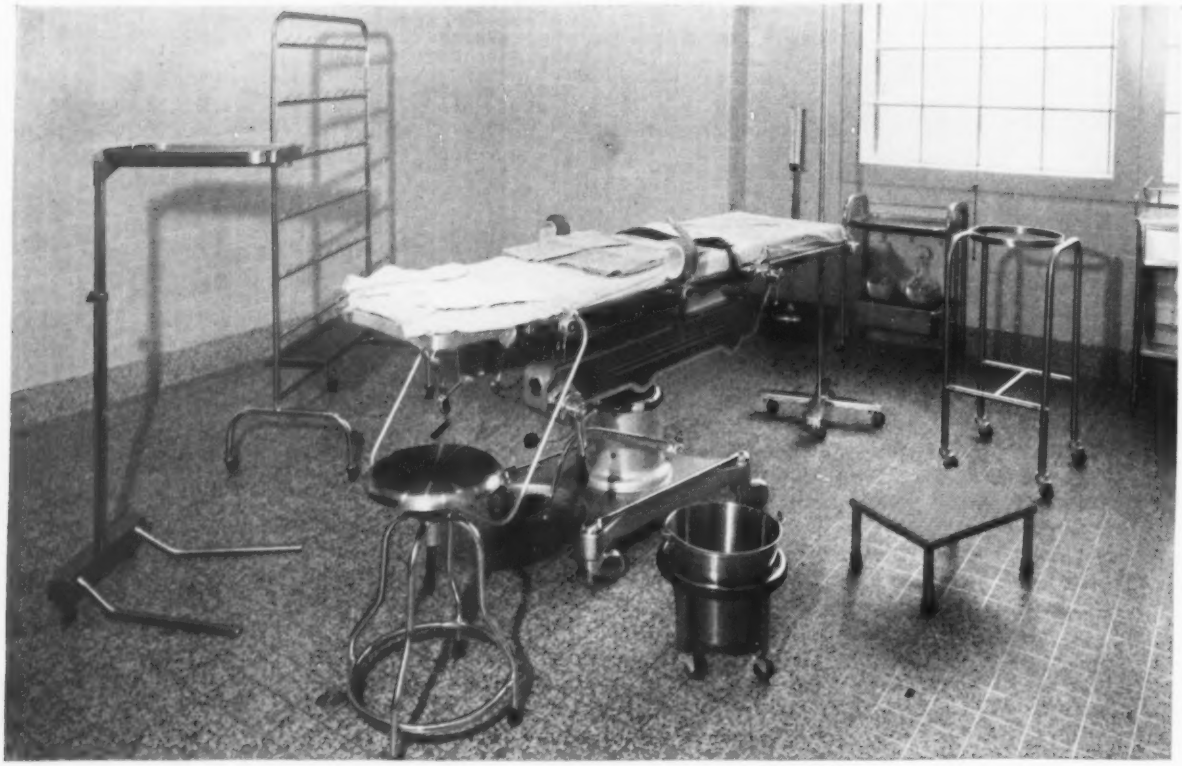

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What's your current cost of cleaning and general housekeeping? Chances are it has been going up along with all other services. That's why hospital equipment made of Republic ENDURO Stainless Steel is a better-than-ever investment for you now.

ENDURO equipment is easy to clean and to keep clean . . . even by unskilled help. Usually a quick rinse and a wipe or a simple washing with soap and water will do it. Very seldom will ENDURO equipment need hard, time-consuming scrubbing.

What's more, ENDURO stubbornly resists rust and corrosion. It resists abrasion, denting and scratching. It has no surface covering to peel, chip, crack, or wear away.

That's what we mean by ENDURO's *cleanability*. It cuts cleaning time . . . frees hospital help for more productive duties . . . stretches your operating budget by lightening your housekeeping. And, ENDURO equipment *lasts and lasts*, paying you long-term savings. Your equipment supplier can give you more details, or write:

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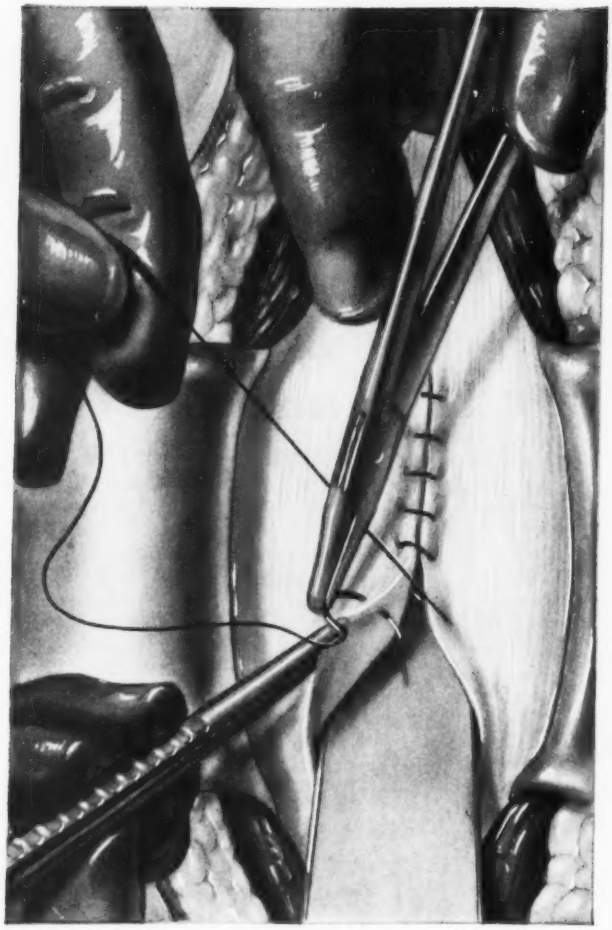

Wounds sutured with smaller sizes of D & G surgical gut on Atraumatic needles have less trauma and heal faster and more evenly.

faster wound healing

Patients move about more freely after their operations and are out of the hospital sooner when their wounds have been closed with a minimum of trauma. Davis & Geck offers two modern aids to faster and more even healing:

1. Davis & Geck "timed-absorption" surgical gut—in small sizes
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Davis & Geck surgical gut sutures may be used in smaller sizes than might be expected because *diameter for diameter* the tensile strength is unexcelled by any other brand. By a unique process of control, these "timed-absorption" sutures offer maximum resistance to digestion during the early days when the wound is weakest. After healing is under way, digestion is more rapid until completed. Smaller suture sizes permit closer approximation and provoke less trauma. The patient's convalescence is smoother.

faster healing with Atraumatic® needles

In suturing with Atraumatic needles there is less tissue trauma, faster and more even healing. The D & G Atraumatic needle is joined to its suture smoothly. Needle and suture are about the same diameter. No big eye and double strand of suture are dragged through the tissue. Sutures on Atraumatic needles are economical, too. Surgery is easier and faster, needles are always sharp, *no time is lost while the nurse threads needles.*

For better wound healing, use the smaller sizes of Davis & Geck "timed-absorption" sutures, with an Atraumatic needle attached, on your next wound closure.

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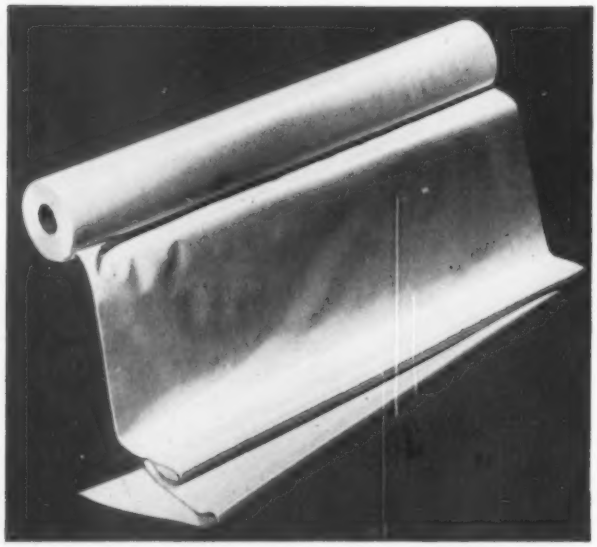
Amazing new *Plasticon* by Continental



Opaque-white 8 mill Plasticon sheeting for all kinds of hospital uses. Available in 25, 50, 100 yard rolls—widths 36 and 48 inches.

Plasticon tailored-to-fit covers fit any standard mattress regardless of thickness—simply tuck-in extra film underneath—saves time and lots of hard work.

The new hospital sheeting that stays soft and pliable

Never before a film like Plasticon. It stays amazingly soft and velvety even after continuous boiling, sterilizing and autoclaving — doesn't get hard, brittle or rubbery.

Yes, this new lightweight Plasticon is really tough and rugged — withstands all grueling hospital wear and tear. It's oil-water-grease proof — unaffected by mild acids, brines or alkalies — resists stains and washes or wipes clean with ordinary soap and water. Plasticon is perfect for all hospital uses and applications. Plasticon is opaque white available in 36 and 48 inch widths — thickness is 8 mills (.008). *Price is only $.90 a square yard.* 48-inch width is $1.20 per yard — and $1.15 per yard in 50 and 100 yard rolls.

Plasticon Mattress Protectors

Protect expensive hard-to-replace mattresses with new Plasticon. And it's so inexpensive because *Continental Plasticon Covers fit all standard-size mattresses regardless of thickness.*

No more wrestling with big bulky mattresses — simply slip on a tailored-to-fit Plasticon Mattress Protector and that's it. Also easy to store — folds into compact package.

Plasticon saves time and work — gives better protection and lasts longer, too. Plasticon is the best protection you can buy — and it's so inexpensive. Costs only $5.00 each. Quantity savings . . . $55.00 per dozen.

Other Plasticon Products by Continental

Pillow Protectors — the silky soft yet rugged qualities of Plasticon make it an ideal material to cover pillows. Zipper style only.

Plastic Aprons — these tough boilable aprons will outwear and outlast ordinary plastic material. Extra savings in quantity purchases.

Don't delay — write now for Plasticon details — do it today!

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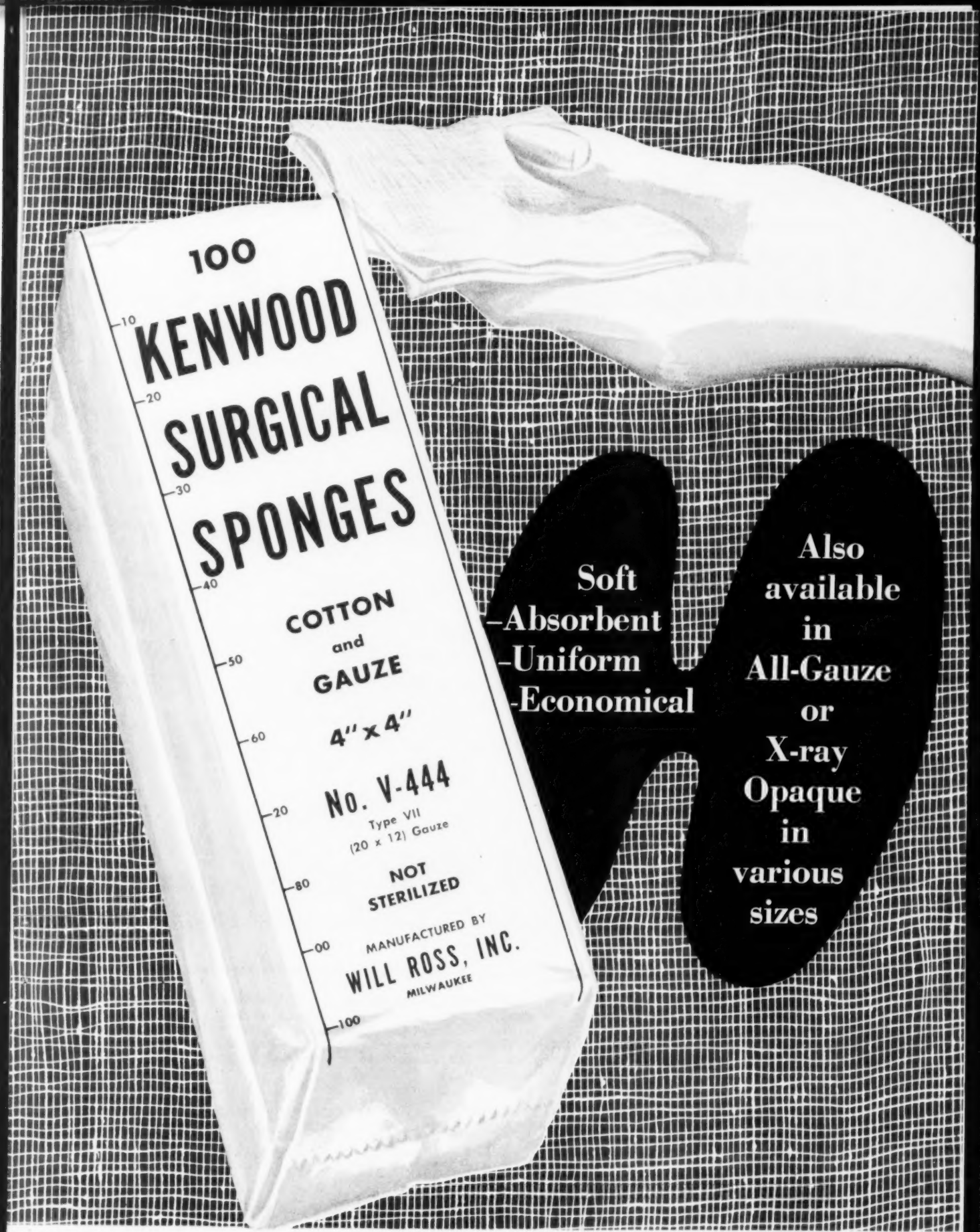

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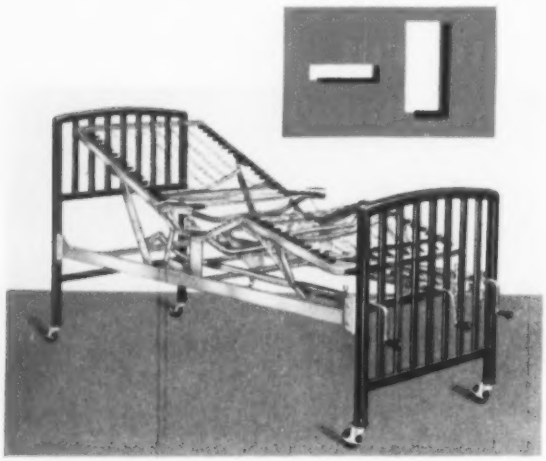
Do you require a plain bed for general use? Will you need a bed equipped with Safety Sides . . . or do you want a bed which handles a wide variety of accessories such as a Balkan Frame, Irrigation Rod or Shaped Fracture Bar? Your requirements can be supplied exactly because Simmons has five handsome bed end styles available three ways: plain (indicated by -1 after the bed number); equipped with brackets for safety sides (indicated by -2 after the bed number); and with All-Purpose ends to handle a variety of special equipment (indicated by -3 after the bed number).

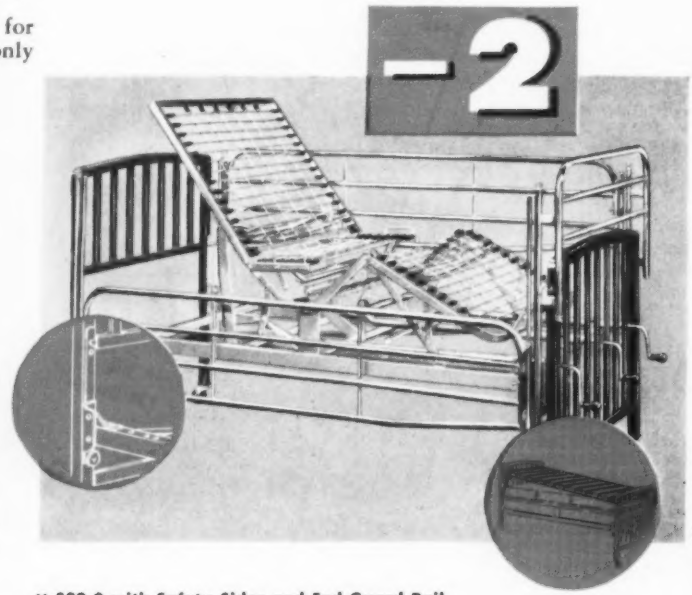
Selection of the style of bed end you want, made for the accessories to fit your specific requirements, is only part of the story of *complete flexibility* you get with Simmons. In addition, Simmons gives you a choice of three types of posture springs: Simmons Improved Deckert Multi-position Spring — L-171, Simmons Improved Two-Crank Spring L-148, Simmons Self-Adjusting Spring — L-190.

To be sure you get the best combination to fit your hospital requirements — call your Hospital Supply Dealer.



H-800-1 Standard bed.

A practical standard style designed for years of usefulness. Bed illustrated above is the H-800-1, seven filler style, shown with Deckert Multi-position Posture Spring.

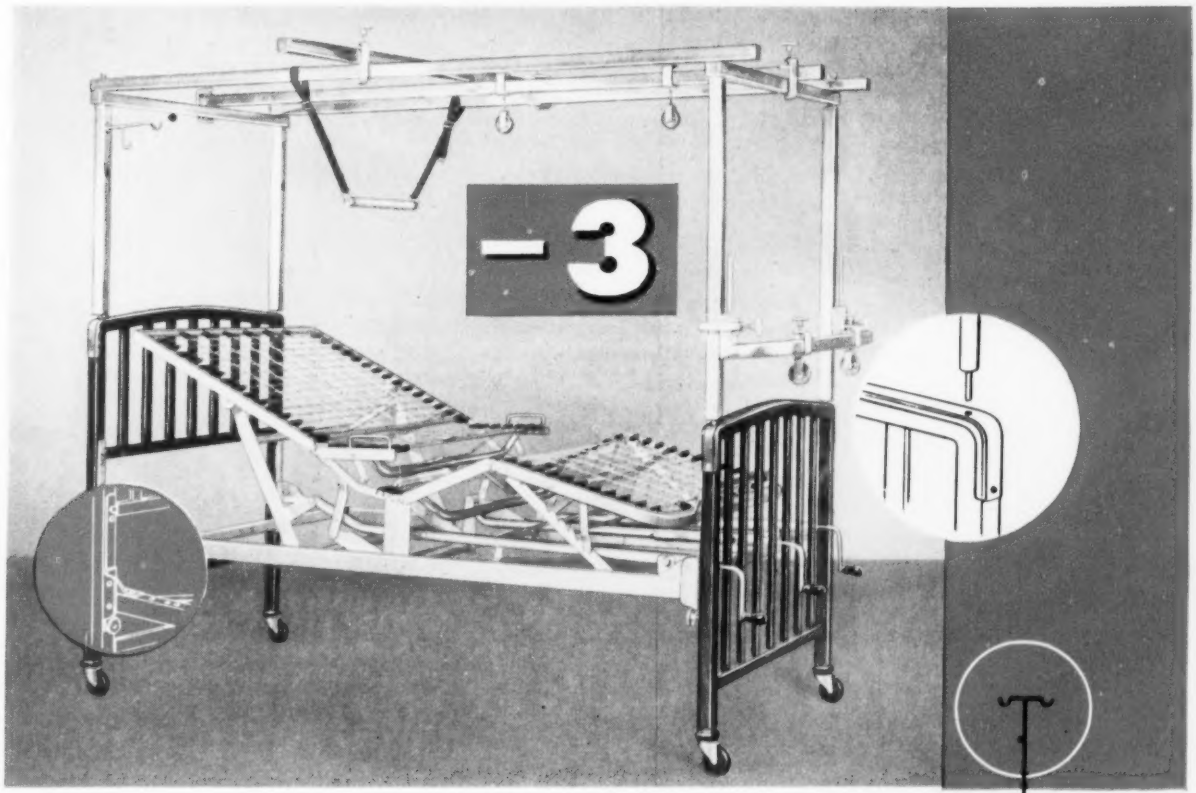


H-800-2 with Safety Sides and End Guard Rail.

Bed illustrated above is the H-800-2, seven filler style with brackets for Safety Sides. Its room-to-room adaptability fits this bed perfectly into the hospital's plan for standardizing equipment. In addition to Safety Sides and End Guard Rail, all -2 beds will also accommodate Simmons Bradford Frame.

Choose your bed end styles from these attractive designs

the right type of bed end as 1-2-3, with SIMMONS!



H-800-3 All-Purpose hospital bed.

In the H-800-3 All-Purpose bed you have maximum utility. The accessories can be brought to the patient rather than the patient to a special bed for treatment. This versatility makes the All-Purpose bed ideal for general, orthopedic and post operative treatment wherever safety-sides, fracture equipment or intravenous irrigation is required.

H-800-3 with Shaped Fracture Bar and Irrigation Rod

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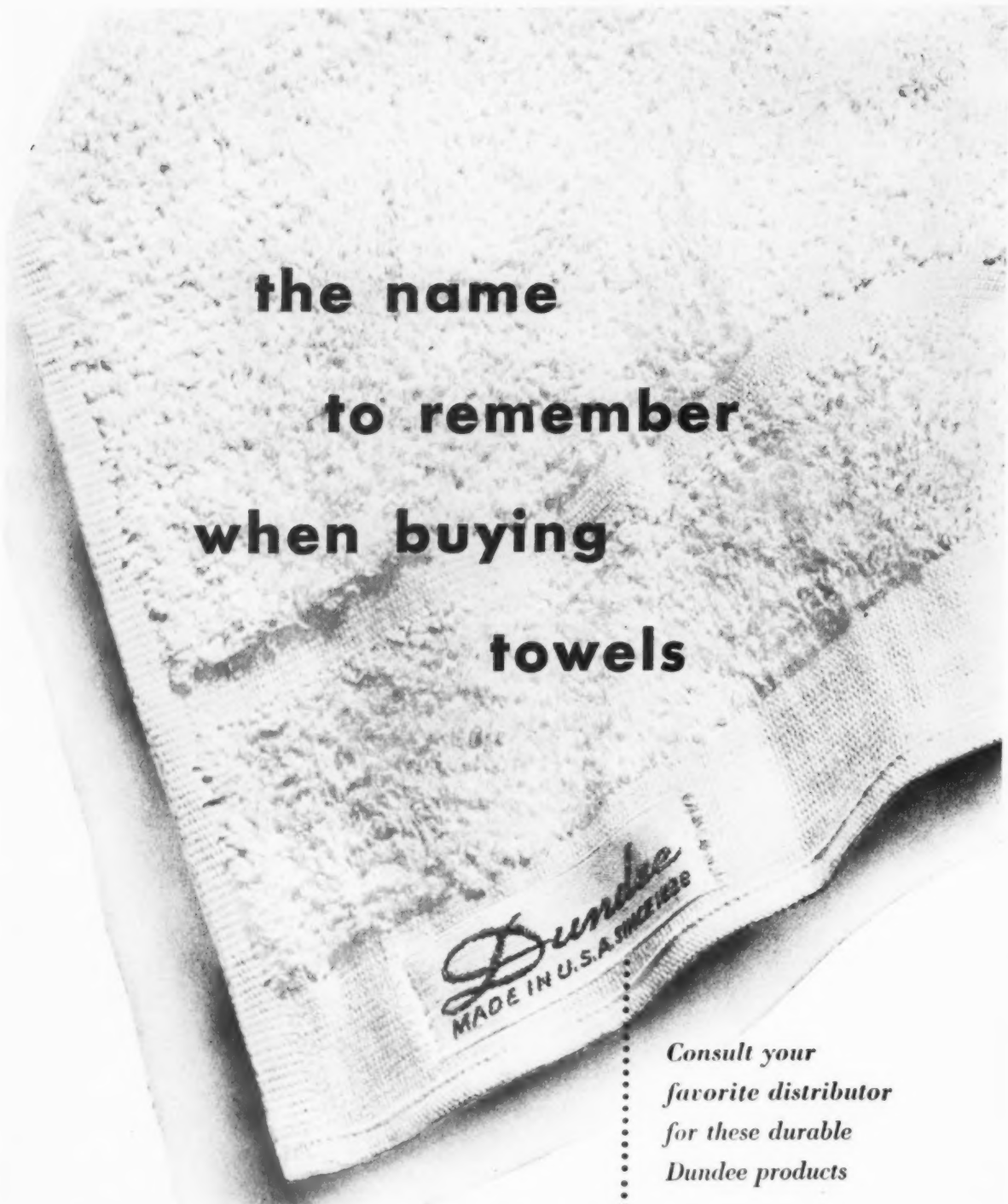

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For the effective cleaning of all surgical glassware, instruments, rubber goods, and accessories. Quickly and easily dissolves blood, loosens tissue and other body soils without scrubbing. Simple and safe to use.
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...a safer, faster more effective cleaner for surgical and laboratory equipment
• No more rubbing or scrubbing of instruments and glassware. Simply soak in **Dynaklen** solution and rinse. Dried blood, plasma, serums, pyrogens are all removed completely, leaving glassware and instruments chemically clean.
Dynaklen saves money, too, because just one ounce makes a gallon of solution that can be used at once or stored indefinitely.
Safer, too . . . **Dynaklen** contains a non-active coloring to prevent possible confusion with other uncolored chemicals.
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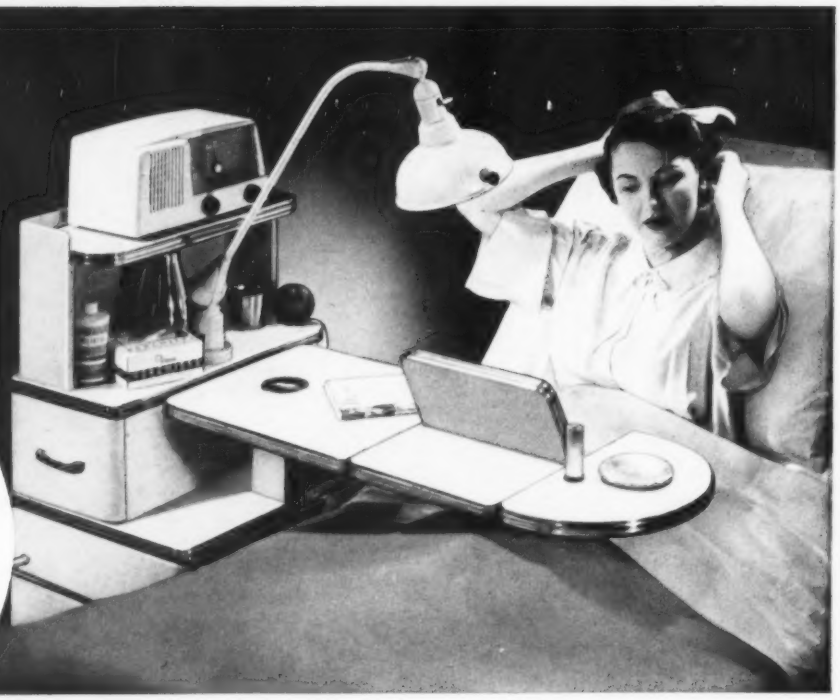

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This beautifully and functionally designed piece of furniture encourages patients to serve themselves. It makes quickly available such often used conveniences as adjustable lamp, radio, outlet for razor, fan, etc., makeup mirror, book rest, towel racks, wash basin and soap dish and other facilities. Contains drawers and storage cabinet, too. Compact and exceptionally easy to clean.

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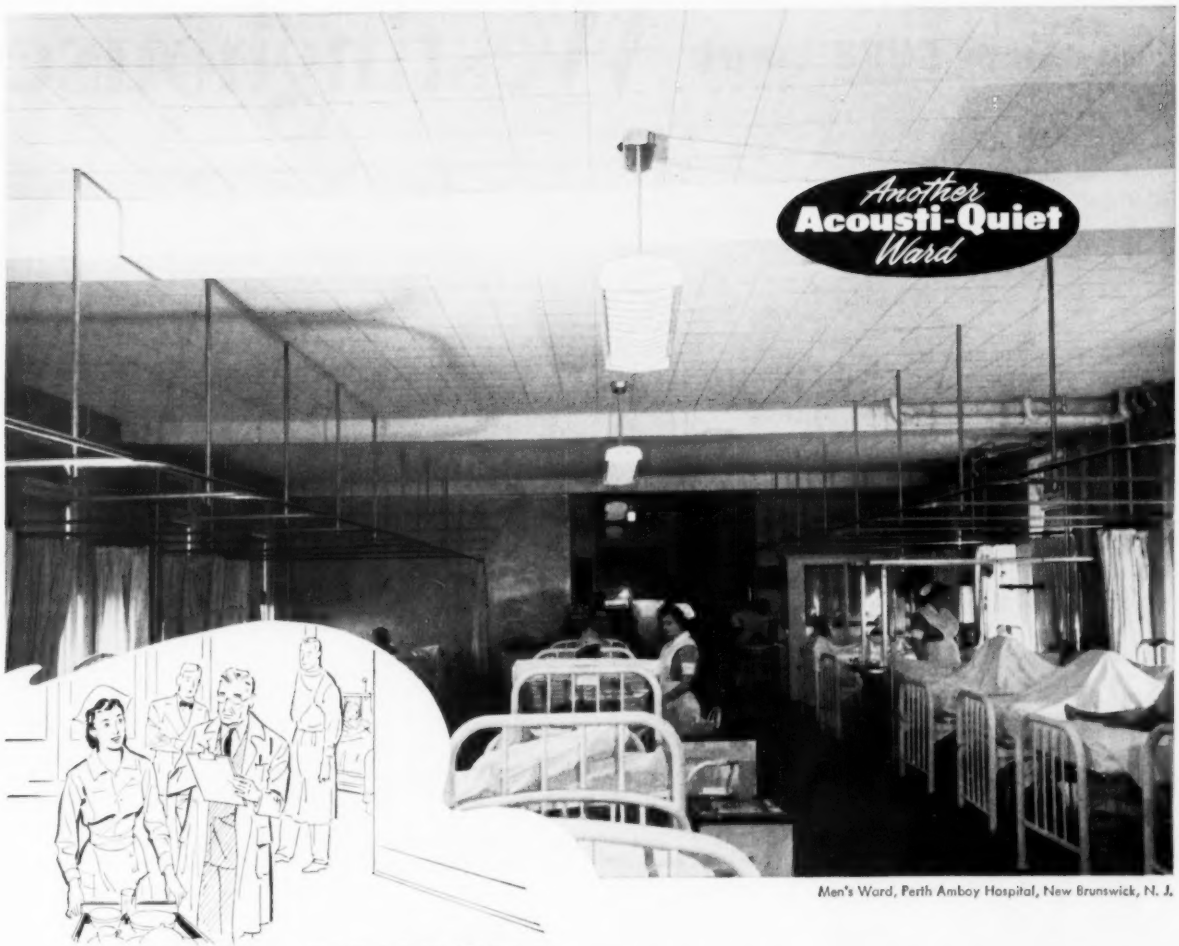

Men's Ward, Perth Amboy Hospital, New Brunswick, N. J.

QUIET, PLEASE...people "on the mend"!

Cases vary and treatments differ, but there's one thing *all* hospital patients have in common—they need *rest and quiet!* Yet, in many otherwise fine hospitals, this simple prescription is not filled. Patients are denied the soothing, healing benefits of quiet comfort because the unavoidable noise of daily hospital tasks is *needlessly permitted to go unchecked!*

Low-Cost Answer

The economical solution to this problem, hundreds of hospitals have found, is Acousti-Celotex Sound Conditioning. A sound-absorbing ceiling of Acousti-Celotex Tile checks irritating, disturbing noise in wards, nurseries, operating and delivery rooms, corridors, lobbies, kitchens, utility rooms. It brings restful quiet that aids convalescence and also improves the working efficiency of hospital personnel.

DOUBLE-DENSITY—As the diagram shows, Acousti-Celotex Tile has two densities. *High density* face, for a more attractive finish of superior washability, easy paintability. *Low density* through remainder of tile, for controlled sound-absorption value.

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Acousti-Celotex Tile is quickly installed, requires no special maintenance. Its unique *double-density* feature (see diagram) provides excellent sound-absorption value plus a surface of remarkable beauty and washability. Can be washed *repeatedly* and painted *repeatedly* with no loss of sound-absorbing efficiency.

MAIL COUPON TODAY for a Sound Conditioning Survey Chart that will bring you a *free analysis* of your particular noise problem plus a factual free booklet, "The Quiet Hospital." No obligation.

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New Westinghouse Hospital Elevators are contributing to the efficient operation in this new building. Westinghouse Hospital Elevators were chosen to meet modern hospital standards of dependability, quietness and smoothness of operation—24 hours a day. This means moving patients, staff, food, drugs and delicate equipment quickly, quietly between floors of this modern hospital.

Mr. William L. Wilson, Mary Hitchcock Memorial Hospital Administrator, reports: "The Westinghouse elevators are living up to every expectation and are equipped to meet the rigid requirements of modern hospital schedules."

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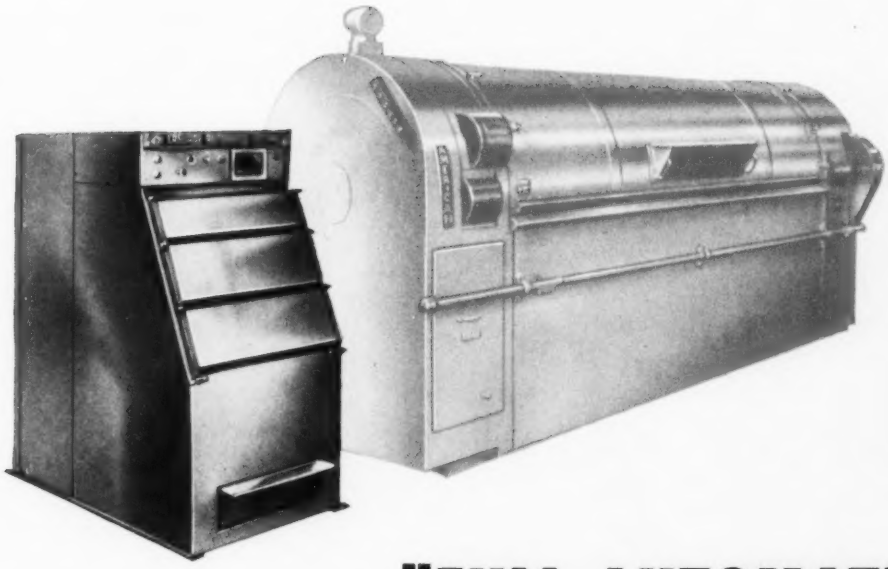
Hospital Elevators



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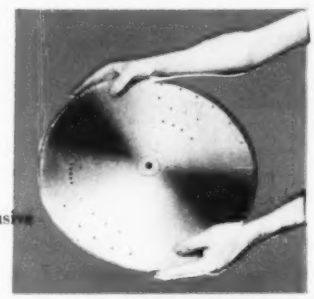

American's exclusive Formula Plate

SEE THE REAL MEANING OF "AUTOMATIC" WITH THE CASCADE FULL-AUTOMATIC CONTROL

- **Admits and measures water to correct level for each bath.**
- **Steam-injects mechanically measured supplies at proper intervals.**
- **Regulates bath temperatures by admitting correct mixture of hot and cold water and steaming important baths.**
- **Times each bath (after prescribed washing conditions have been secured), drains washer and proceeds promptly to next bath.**
- **Completes entire washing cycle without any attention from washman, and signals when washing formula is completed.**

With American's CASCADE Full-Automatic Control, your washing formula is completely controlled *automatically* . . . with the positive assurance it will be correct every time. Remember, if your washman can change manual switches and controls, you do *not* have completely automatic washing.

Each step of American's fully automatic washing cycle is controlled by an exclusive American Formula Plate. Prepared to your exact specifications for your particular washing classifications, these Formula Plates represent *your* choice, *your* order. No one can alter them. Changing plates for different washing classifications takes only a few seconds . . . far less time than setting a bank of switches and controls, and there's no danger of human error or confusion.

Proved by its outstanding performance in nearly two thousand installations since 1938, American's CASCADE Full-Automatic Washer Control follows your orders *explicitly*. It doesn't forget, doesn't decide for itself, doesn't overwash, doesn't waste or skimp on supplies. Each load washed is of the same high quality because the formula you selected is followed — *must* be followed — *automatically*.

The CASCADE Full-Automatic Control can be used with your present washers, or with any new American CASCADE Washer. Write today for full particulars, or ask your American representatives to show you case histories of remarkable savings made with CASCADE Full-Automatic Controls.

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These long-wearing easy-to-handle Commercial Aluminum Stock Pots come in 6-quart up to 80-quart capacities. Extra weight in bottom assures long life. Large steel handles are securely riveted. Available in standard, medium and heavy weights. Also with faucets.

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only 1⅓¢ PER SERVING

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There's a bigger difference in quality than there is in cost

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Another Royal plus!

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Portable vanity, reading rack or bedside instrument table with rubber scuff guards that protect the finish of the smart island base. 14" x 30" Formica top adjusts from 29" to 45" high. 2" ball bearing casters. Vanity compartment with mirror and removable porcelain tray and reading rack double-hinged for use from either side. Stainless steel tray optional.

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Come see us in Room 652
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Stop worrying about bruised walls!

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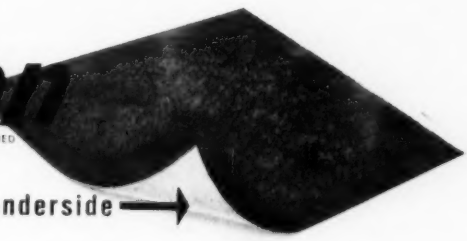

Astounding but true, Kalistron-covered walls, even after years of abuse, don't show ugly bruises or scrapes. Records at leading hospitals, hotels, schools, other heavy-traffic buildings prove it. Miraculous? Here's the secret: Kalistron is different, it's made by fusing color to the *under*side of clear, super-tough plastic sheeting. No surface wear can get at that *under*side color.

Also, that *under*side feature means wonderfully rich color-depth. As a result, Kalistron walls are more beautiful to start with. And that beauty lasts! You get big savings in wall maintenance costs.

Exceptional also for upholstery, *with 3-way-stretch fabric-backing*. Available in special colors for harmonizing of walls, furniture and decorations.

Write for detailed information.

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NEW GARLAND in Granite Gray Black Japan or Stainless Steel

Automatic Oven Lighting

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Look at Garland! Improved design . . . steps up operating efficiency, reduces maintenance to a minimum! *New features* . . . provide greater convenience, even greater flexibility! *Engineering advancements* . . . insure top performance and even longer life! And now you have your choice of three finishes: Black Japan, Stainless Steel, and our new glamorous Garland Granite Gray!

Choose Garland in the exact arrangement of open grate, griddle, and Spectro-Heat hot top sections you want. Leading restaurant equipment dealers everywhere recommend and sell Garland. *All Garland Units Are Available in Stainless Steel* and equipped for use with manufactured, natural or L-P gases.

See Garland Booths 369-370 AGA Combined Exhibit National Restaurant Convention and Exposition May 11th to 15th, Navy Pier, Chicago.

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In Canada, IT'S GARLAND-BLODGETT, LTD., DISTRIBUTORS, TORONTO, ONTARIO

Small Hospital Questions

Canned vs. Frozen

Question: I am interested in obtaining information concerning the comparative factors regarding the purchase of canned fruits and vegetables as against the frozen fruits and vegetables. If you have any information concerning this problem, I would be very grateful if you could send it to me.—L.R.F., Ark.

ANSWER: Many considerations must necessarily enter into any decisive recommendations with regard to this query. The comparative cost of the canned *vs.* the frozen product is but one of these considerations. The matter of storage facilities is another: almost every institution is equipped with means for the proper storage of canned items in quantity, thus permitting advance purchasing often at considerable financial advantage. The frozen item, on the other hand, requires far more expensive storage space of a type with which few hospitals at present are adequately equipped. The cost of such sharp-freeze storage cannot be disregarded when comparing costs of canned *vs.* frozen; it can only be written off in situations where daily deliveries of frozen items can be expected.

Perhaps most important in buying food is the selection of items that will please the taste of the clientele and meet the specific purpose for which the product was purchased.

Only the practicing dietitian who knows how to select the canned or frozen item best suited for a specific purpose can advise the purchasing agent what is best to buy to satisfy the needs of a given institution. Books like the "Canned Food Reference Manual" published by the American Can Company, New York City, give accurate data on total solids and portion yield. Most frozen products also state portion yield. Hence the comparative cost per portion of canned and frozen peas, for instance, can readily be determined. But, we repeat, and every dietitian will agree, the comparative raw food cost is not the whole story when purchasing foods.

In 1947 the American Hospital Association published an excellent booklet covering specifications for the buying of canned fruits and vegetables and more recently (1952) "Quantity Buying Guides" by Adeline Wood was published by Ahrens Publishing Co., Inc., New York. "Food Purchasing Guide for Group Feeding" by Rosalind C. Lifquist and Edith B. Tate is especially helpful since it gives data on fresh, canned, frozen and dried vegetables and fruits, and is available from the Superintendent of Documents, Washington 25, D.C., for 25 cents. — MARY P. HUDDLESON.

Distributing Drug Charges

Question: What is considered the proper and most economical way to distribute charges for drugs purchased to various stations in a 150 bed hospital which does not have a stores clerk or a pharmacist? We do have a perpetual inventory system.—T.J., Ore.

ANSWER: The thought of a 150 bed hospital operating without a pharmacist rather leaves me cold, since our 100 bed hospital has a full-time pharmacist, who has proved to be of great value to the hospital and his department. However, I once operated a hospital where we did not have a pharmacist, nor did we have a stores clerk, but were able to handle the drug charge distribution in the following manner.

The drugs in the drugroom were maintained on a perpetual inventory, and all drugs ordered from the department were requisitioned in writing. The director of nurses, or assistant director of nurses, dispensed the drugs to the various departments. Each week the requisitions were priced by office personnel, and posted to the perpetual inventory system.

The requisitions were then sorted by departments, and total costs were obtained by departments, thereby enabling us to make the necessary departmental charges in our month-end reports.

We then had a patient's drug charge slip, which was filled out each night, after midnight, by the 11 p.m. to 7a.m. charge nurse on the floor, from the patient's chart, where all drugs given for the previous 24 hours were listed. These slips were priced in the business office the following morning and posted to the patient's account.

Such a method is basic, and could be used whether or not there was a pharmacist in the hospital. The efficiency of such a plan might be questioned because of the use of nurses for these functions; however, they come the nearest to the essential qualifications for a person who is handling drugs.

I would like to go a step farther, however, and urge that any hospital of 100 beds or over give serious consideration to obtaining the services of a pharmacist.

Even a part-time agreement with a pharmacist employed in one of the local drug stores is better than no pharmacist at all, and his services will be more than paid for by the good that he can do for the department. Besides dispensing drugs, he can be of infinite value in cooperating with the medical staff in establishing a standard formulary; in preparing a stock of antidotes and solutions; in compounding presciptions, and in maintaining adequate records.

Another of the important functions of the pharmacist is purchasing. This is a time-consuming task, and must be conducted by a person who is well versed in drugs and their uses. The pharmacist is the most logical person for this.

The pharmacist will also inspect and supervise the handling of drugs. Therefore, I urge all administrators who hesitate to employ a pharmacist because of the cost involved to realize the pharmacist can justify his salary, many times over, in his service to the hospital.—REX VON KROHN, *Memorial Hospital, St. Joseph, Mich.*

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

made to outlast

any hospital... cut maintenance too!

In times like these it's just good business to take a second long look when selecting windows for your hospital buildings.

Cost, of course, is a factor, but the WAY Cost is figured is the important thing.

How long will the windows last?

What about maintenance?

Those two questions are keys to better buying and here Ceco-Sterling Aluminum Double-Hung Windows win on both counts. Made of ageless aluminum, they give rugged life-time service . . . will outlast any hospital . . . won't rust, rot, warp, or swell . . . permanent weather seal . . . nothing make-shift . . . nothing to deteriorate, wear out or replace.

When it comes to maintenance Ceco-Sterling Aluminum Windows deliver a plus value. No painting is necessary and cleaning is a mere matter of wiping.

Here is Ceco-Sterling **Double-Hung** Aluminum Window, series 200-B

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Cut down Care

Data on "Flexachrome" Floors courtesy The Tile-Tex Division, The Flintkote Company, 1232 McKinley Ave., Chicago Heights, Ill.

Floors like these give any room a lift—add a rich, colorful tone. And regardless of traffic, they'll stay like new for years . . . with only the simplest of cleaning!

They're resilient flooring materials made with VINYLITE Brand Resins. That means lasting flexibility—in both tile and continuous types. It means fresh, clean colors that *stay* fresh and clean. It means low maintenance costs.

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wire from Washington

REORGANIZATION PLAN

A big wind is blowing down here in Washington. Bills, reorganization plans and investigations fill the air. When they settle down, it may well be that only one will be of any lasting importance—the creation of a new cabinet department to handle health, education and welfare matters.

There is nothing new about the plan to elevate Federal Security Agency to a cabinet level department. Actually this was one of the Republican ideas, buried in the political and economic upheaval of the early Thirties. The news is that the change finally is taking place. The American Medical Association's house of delegates, meeting here in special session to discuss the new federal department, not only approved the idea but actually became enthusiastic after the plan had been fully explained; in advance, there was some thought that the A.M.A. might decide to fight creation of the Department of Health, Education and Welfare. (For details of what the new department will contain and how it will operate, see page 73.)

HEALTH BILL

Some interest has been aroused in Congress on two other measures that would be of great interest to hospital people. One is the proposal of a group of Republicans in House and Senate for the federal government to underwrite extension of voluntary health plans, setting up a financial framework in which hospitals could operate on a reasonably secure basis. It would closely follow recommendations of the Truman Health Commission, whose report was published a few months ago.

The bill is similar to one introduced four years ago, but it has some additional provisions. The new bill would emphasize construction of diagnostic facilities and health centers with Hill-Burton funds. To make federal money available for this purpose, the maximum annual H.B. authorization would be increased from $150,000,000 to $175,000,000. (For the last three years Congress has held a tight fist on H.B. funds, appropriating only about half the presently authorized $150,000,000.) The bill also would:

1. **Put a special tax** of not less than 3 per cent on family incomes up to $5000. The federal government would distribute the money to states on a population-income formula similar to Hill-Burton, ensuring more per capita in grants to poorer states. The U.S. dollars, plus varying amounts from the states, would be used to (a) pay hospital and other health insurance premiums for low-income families, and (b) make long-term, interest-free loans to help in establishing health service insurance plans. This is one of the new features of the bill.

2. **Require states,** working through a health council, to set up health regions and areas, each serviced by hospital, medical and surgical insurance plans. The plans would have to guarantee diagnostic examinations, 30 days' hospitalization (including nursing care), and x-rays, drugs and appliances.

3. **Offer U.S. funds** to assist in establishing and maintaining adequate public health services.

4. **Pay medical and dental schools** $500 for each student, plus an additional $500 for each student in excess of normal enrollment. Degree schools of nursing would receive $200 for each student, plus the high incentive of $1000 for each additional student. Diploma schools of nursing would get lesser amounts, and all "health science" schools could apply for grants of up to 50 per cent of construction costs.

5. **A 20 year program** for expanding hospital and other facilities would be undertaken on the recommendations of a federal health study and planning commission.

In the Senate, the new bill is sponsored by Senators Irving Ives of New York and Ralph Flanders of Vermont. House sponsors are Robert Hale of Maine and John Javits of New York. When the idea was first introduced in 1949, there were a dozen more sponsors. Many of these have trailed off in other directions, while a few are no longer in Congress.

There is no indication whatever that this plan will have support of Senator Taft, Speaker Martin or other administration leaders. A reasonable assumption is that, even should hearings somehow be arranged on either side, the bills will not come to a vote this session. The thing that should win a measure of public support—the fact that these bills would carry out the Truman Commission recommendations—will at the same time be a detriment in Republican top circles, where the commission report is not on display.

NURSE SCHOOL BILL

A bill with better prospects is the familiar Bolton Bill extending financial help to nursing schools only, the fourth or fifth version of which has been introduced by Rep. Frances P. Bolton, Ohio Republican.

Mrs. Bolton has patiently and persistently used every legislative and conciliatory device at her command to advance this idea. She has succeeded to such an extent that there is not much more room for compromise. It now is pretty much a question of whether Congress does, in fact, want to use federal money to stimulate nurse education.

Although consistently rebuffed herself on this bill, Mrs. Bolton's patient, determined attitude has won over many

former critics. It has only a chance—but if there is any dramatic military event that chance will be a very good one.

Explaining the bill on the House floor, Mrs. Bolton recited the well established need for more nurses, including the fact that a minimum of 65,000 more are required immediately to meet even the minimum demand. Then she added this comment, which so many nurses look for—but seldom find—in official pronouncements on this problem:

"I am well aware that nursing could be made more attractive were hospitals to revamp some of their working hours and conditions. I am well aware that when the nursing profession agrees to certain changes in the training programs now being tried out—when the results of certain experiments in content and timing of curriculums are available—that a little of the burden will be lifted in many places. I am also certain that doctors, too, must readjust themselves to new ways of covering the care of their patients, who, in turn, must be ready to do their part too."

Under Mrs. Bolton's bill, $5,000,000 would be earmarked the first year, $10,000,000 the second, and $15,000,000 the third. States would administer the program, and payments would be on a sliding scale for various types of schools—degree, diploma and practical nursing.

V.A.

A new investigation of Veterans Administration, with particular reference to hospitals, already is under way, even before any official answer has come to the question of whether the Booz, Allen & Hamilton survey was worth the $605,000 it cost.

The new investigation will be on a relatively minor scale; there is no possibility that it will be as thorough or painstaking as the B.A.H. study. It will be done on $50,000 by the House veterans' affairs committee. Three subcommittees have been named to do the work, with Rep. Pat Kearney (R.-N.Y.) heading the investigation of hospitals, Rep. Ross Adair (R.-Ind.) the administration and finance study, and Rep. William Ayres (R.-Ohio) the investigation of housing.

Mr. Kearney has already indicated he expects to plow a lot of hospital ground. He started out by asking a number of experts to come to an executive session and suggest questions to be asked of the V.A. hospital managers. On the basis of these questions, the hospital subcommittee should be in a position to ask key questions. Of particular interest will be the relation between V.A. and private costs per patient day, the extent to which the pauper oath has been abused in admitting nonservice-connected cases, and the possibility of a more efficient coordination of V.A. and military hospitals.

Pat Kearney is a National Guard general. He knows the military and the Veterans Administration, possibly as well as any member in either house. He is active in veterans' associations, but he has not displayed the same pro-V.A. coloration that has compromised so many other lawmakers who have attempted to study Veterans Administration.

Mr. Kearney knows how to get the facts, and so far he has indicated he will get them. What use is made of them after that, by the full committee and the House, is another matter.

BUDGET BUREAU

Veterans Administration is coming in for attention in other ways, too. At a hearing before the House veterans affairs committee, a spokesman for the Bureau of the Budget gave his idea of the root of some of V.A.'s financial troubles in the medical department.

Fred A. McNamara, the bureau's hospital expert, said V.A. refused to hold down its expenses last year to the level indicated by Congress. After Congress had adjourned, and there was no hope for an additional appropriation, the agency instituted its cuts, which provoked complaints from veterans' associations and physicians participating in the home town fee program.

When the abrupt economies were hurting services, V.A. asked for funds to be appropriated early this year, which would allow for a relaxing of economies. Two requests were rejected by the budget bureau, the first for $23,000,000, the second for $16,700,000. The final request, for $6,000,000, was approved by the bureau. This—minus a million dollars V.A. would get from other sources—was also approved.

With the $5,000,000, V.A. is staffing six new hospitals to be opened before the June 30 end of the fiscal year. The remainder will be used for travel funds and to restore some of the cuts in the physician and consultant program.

NOTES:

American Legion and several professional associations are attempting to reach an agreement on nonservice-connected care in V.A. hospitals, but they have not, at this writing, been able to get much closer together. The associations now are reviewing the facts and their separate positions and will try again at a later date.

F.S.A. Administrator Hobby, probably more so than any other Eisenhower executive, has found it almost impossible to dislodge civil service people from policy making jobs and replace them with officials sympathetic with her views. The administrative structure of the new department she will head, plus the President's order removing a few hundred jobs from civil service protection, will make life easier for her.

The state governors' conference—preponderantly Republican—will help shape the work of the new commission to study state and federal relationships in such areas as schools, hospitals and medical programs.

Another study of social security is being undertaken by a subcommittee of the House ways and means committee. Although at first this group appeared to be set up to stop rather than initiate legislation, its chairman, Rep. Carl T. Curtis (R.-Neb.) is bearing down on his assignment and may come up with a series of revolutionary recommendations. One prospect is that a number of programs would be returned to all-state financing and control.

By accident or design, there has been a noticeable change in the doctor draft situation since the first of the year. For one thing, there was a long delay in introduction of the law to amend and extend the doctor draft law, while departments other than Defense carefully looked it over. For another, President Eisenhower backed up recommendations of the Rusk committee and required the services to reduce their calls on doctors for the April-June quarter.

The Modern Hospital
APRIL 1953

LOOKING AROUND

No More Fisc

WHY can't people say what they mean?" we grumbled the other day when our friend Anastasia came into the office.

"Howzat?" she asked.

"Listen to this," we said, reading from a recent speech on federal aid to education by Dr. Alfred Simpson of Harvard: 'The evils of controlness are dissipated by purposing.' That mean anything?"

"Sure," Anastasia said. "When you take handout, keep guard up."

"All right, how about this?" we demanded. "The man says support from national and state funds is needed *'in order to hulwark the adequacy which is residual only in the total fisc.*' How do you like *that?*"

"Great!" Anastasia said enthusiastically. "No place like home to go broke."

Green Stuff

ADMINISTRATORS and, especially, nurses who were looking forward happily to odorless hospitals had their hopes smothered last month when science turned up its nose at chlorophyll. Writing in the *British Medical Journal,* Dr. John C. Brocklehurst, a Glasgow University chemist, reported the results of his experiments with gases, skunks, onions, garlic and perspiration. Chlorophyll had "no deodorant properties whatsoever," Dr. Brocklehurst said, exhaling.

The chlorophyll industry here sniffed indignantly. British experimental technic smelled, an industry representative said, and, besides, the British scientist used a less potent chlorophyll than we do.

Potent, shmotent — chlorophyll couldn't deodorize a hummingbird, an American authority retorted. Dr. Alsoph H. Corwin, head of the department of chemistry at Johns Hopkins Universtiy, explained that chlorophyll compounds sold in the U. S. are crude extracts from alfalfa and include a lot of ingredients besides chlorophyll. Among other things, extracts contain the odoriferous oils which make alfalfa smell like alfalfa. These oils may mask other odors, as a greater malady masks a lesser one, but neither they nor chlorophyll itself, which is odorless, can destroy odors, Dr. Corwin said.

There goes the dream of an odorless, chlorophyll-impregnated hospital. The farmers will have to give alfalfa back to the cows, and drugstores can go back to selling footballs and alarm clocks. As a matter of fact, we've been expecting this. Chlorophyll reached high tide and had no place to go but down, we realized a few weeks ago when we saw a sign on a grocery store counter: "Fresh parsley," this said, "contains chlorophyll—just like toothpaste!"

Toulouse-Lautrectomy

AN ART committee of the United Hospital Fund of New York City, where they think of everything, is working out a plan to put original works of art and fine reproductions in the city's hospitals. A proper selection of art on display in patients' rooms and wards, the committee believes, can have a beneficial effect on patients—a result that is called, reasonably, visual therapy.

The plan is to make a public appeal for pictures suitable for display in hospitals, it was explained. Suitability will be determined by a screening committee of artists, doctors and hospital administrators; pictures that get the nod will be sent along for display in the participating hospitals.

We foresee complications. In the first place, hospitals are going to have to develop art formularies, so obstetric patients won't be exposed to pictures that are just the thing for, say, fractured femurs. Here is a whole new clinical science to be learned; in art as in chemotherapy, what is good for

the heart is probably bad for the stomach. Imagine, for example, what an overdose of Salvador Dali might do to a postoperative gastrectomy! Unquestionably, these and similar problems will become subjects for learned exposition and lively controversy on the hospital convention programs of the future; the Public Health Service will develop "Elements of the Hospital Art Gallery," and the hospital placement bureaus will do a brisk business in curators.

The more we think about this the dizzier it sounds. Right now, in fact, we feel a little faint—quick, nurse, a Picasso!

Helping Hand

IN AN article beginning on page 51 of this magazine, the administrator of a midwestern hospital explains how his own and many other hospitals are caught between laws which require them to permit practice by osteopaths, and regulations which preclude acceptance by voluntary approval authorities because osteopaths are admitted. In presenting this article, neither the author nor The MODERN HOSPITAL takes any position on the merits of osteopathy in relation to medicine as these disciplines are taught and practiced today, though we do report changing opinions on this subject. Rather, it is our purpose to disclose the facts of the dilemma in which these hospitals find themselves, as a necessary first step toward resolving it. As we see it, there is no more to be gained by looking the other way and pretending these problems don't exist than there is by the old method of regarding "osteopath" as a nasty word that shouldn't be spoken in polite company.

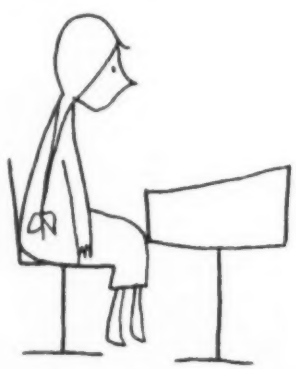
Certainly no medical group or hospital should be compelled by public or political pressure to accept any unqualified practitioner. By the same principle, no such group should refuse to consider whether its own rules need to be reviewed in terms of existing standards. To the extent that they are conditioned by authoritarian dogma as opposed to scientific demonstration, the osteopath's conclusions should be questioned and his activities restricted. To what extent is this true today? Appointment by the board of trustees of the American Medical Association of a special committee to study the relations between osteopathy and medicine is a wholesome step toward determining the answers by findings of fact instead of by assumption. The committee has sent detailed questionnaires to medical society officials and others, seeking the facts about osteopathic education and practice. The facts will determine what can and should be done about the hospital dilemma described in this issue, and the relations of osteopaths, physicians and hospitals generally. Whatever the findings, it seems plain that what the osteopath needs today is the physician's helping hand, instead of his clenched fist.

One-Card Deck

THE Republican administration, it was hoped, would bring order out of the chaos in Washington. Reorganization of the federal services promised to deliver the efficiency and economy everybody longed for.

Well, now we have a reorganization plan—for a new federal department of health, education and welfare (see page 73). As it turns out, however, the biggest hospital service in the federal government, the Veterans Administration, is to remain outside the new department. So are the next biggest, and the next biggest, and the next biggest—the armed services hospital systems.

Aiming at efficiency and economy in government a couple of years ago, the Hoover commission recommended a unified federal medical department. To those who favored the Hoover plan, the present reorganization, though widely hailed as a step in the right direction, looks like a shuffle of a one-card deck.



One-Room Schools

IN RESPECT to its physical facilities, at least, education is far ahead of medical care in the United States, a friend of ours with a philosophic bent observed recently. Long ago, he pointed out, educators abandoned the concept of the one-room school. Instead of building a schoolhouse at every crossroads, school boards today send buses over the hard roads to bring the children to town, where modern school plants provide facilities for all the child's, and the community's, educational needs.

"In the hospital field, we're still building one-room schools at the crossroads," our friend said. "For all their technical excellence, even our new hospitals provide for only a fraction of the individual's and the community's health needs." To compare with the modern school, he continued, the hospital today, in addition to the usual facilities for diagnostic and short-term care, would have to have an expanded outpatient service, with doctors' offices and public health offices and laboratories; provision for patients with chronic illnesses, including mental disease and tuberculosis; convalescent and nursing home accommodations, and facilities for preventive medicine and health education programs reaching the entire community.

Of course, you can't build that kind of hospital at every crossroads, our friend concluded, and you don't need to. "Hospital patients, like school children, can be taken to town on the hard roads," he said. "It's time we stopped building one-room schools for sick people."

This Is Administration?

FROM *Time* magazine's obituary: "Stalin was an administrative genius. . . . It took skill to pick devoted men, to enlist their talents while subduing their ambitions, to reward or discard, flatter or blackmail, soothe or scourge, at the necessary moment. Stalin governed by a cunning balancing of tensions, and was himself aloof and unhurried."

The Osteopaths and the HOSPITAL SYSTEM

Public hospitals in a number of states are caught in a damned-if-you-do-and-damned-if-you-don't squeeze between the law and voluntary approval authorities

LOUIS C. BROWN
Administrator
Hamilton County Public Hospital
Webster City, Iowa

OSTEOPATHS have been practicing their kind of medicine for some time. As one looks back and follows the progress they have been making and the problems their practice has created, it seems certain that the static electricity generated between medical practice and osteopathy will not be grounded without discussion, planning and probably some major concessions on both sides.

This problem never seriously affected me until I became associated with a hospital which permitted osteopaths to admit and treat patients. Two years ago, after accepting a position as administrator of this hosptial, I applied for both personal and institutional membership in the American Hospital Association. The association informed me that such memberships could not be obtained because the hospital was not registered with the American Medical Association, which does not accept any hospitals whose facilities are used by "nonmedical practitioners."

This situation is not one of our own choosing. Chapter 347 of the 1950 Code of Iowa relates specifically to the establishment and operation of county public hospitals. Section 347-18 of this chapter deals directly with discrimination, and it states: "In the management of such hospital, no discrimination shall be made against the practitioners of any recognized school of medicine; and each patient shall have the right to employ at his expense any physician of his choice; and any such physician, when so employed by the patient, shall have exclusive charge over the care and treatment of the patient; and attending nurses shall be subject to the direction of such physician."

To clarify the reference to "practitioners of any recognized school of medicine," it should be noted that osteopaths and chiropractors are licensed to practice in Iowa, and their schools are recognized here in the state as the law is written. The graduates of these schools are required to pass the same basic science examinations as are required of graduates of medical schools. It should be stated here that only the osteopaths, among the nonmedical practitioners, to my knowledge, are practicing in county hospitals in the state. It should also be stated that some of the 32 county hospitals in this state do have recognition with the American Hospital Association and the American Medical Association, but there are no osteopaths on the staffs of these hospitals.

"The Missouri decision does not prevent a hospital board from excluding an individual physician or osteopath from practicing in the hospital but makes it plain that any such exclusion must be based on individual qualifications and must not reflect discrimination against practitioners of any 'recognized school'."

Thus it is plain that the governmental hospitals are in a peculiar situation, caught between the conflicting forces of governmental and voluntary regulatory authorities, with the stronger of the two necessarily being the law under which they operate.

From a legal standpoint, the American Hospital Association and the American Medical Association are within their rights, being private voluntary associations, in declaring what regulations shall bind their members. A graduate of a course in hospital administration who is in the same predicament as I am told me that after bringing this problem to his course preceptor and director, he was told, "If you can't get the hospital rec-

ognized, leave it and take another job."

I wonder if this is the way the problem is to be solved? It seems to me that the problem has reached such magnitude that more reasonable and concerted thought should be given to it.

Within the last six months here in the state of Iowa, in three separate county hospitals located in different parts of the state, there have been public disputes about the right of osteopaths to practice in the hospitals. "Five Osteopaths Protest 'Ban' by Hospital," said a newspaper headline in one case. "Five Physicians Resign From Hospital," said another, and "Seven Quit Hospital Staff," said a third. In all three instances, the hospitals were new and the organization was being completed for the beginning of operations when the flare-up came. In the first hospital it was a matter of restricting medical staff privileges to five medical doctors. There are five medical doctors and five osteopaths in the immediate area which this particular hospital serves. The newspaper pointed out that the osteopaths served areas in the county comparable to those served by the practice of the medical doctors. An interesting point in connection with this particular dispute is that at a hearing that was held by the hospital board of trustees, the osteopaths were represented by their legal counselors, while neither the hospital organization nor the medical association was represented by counsel. As a result of this meeting, the osteopaths were given the same privileges as the M.D.'s in the admission of patients. However, no medical staff organization had yet been established when I last checked with one of the board members at this hospital.

The situations which arose in the other two hospitals were similar; although the medical doctors resigned from their respective staffs in these cases, they continued to admit patients to these hospitals. The boards never accepted their resignations. Recently an agreement was reached in one of the two hospitals, where only one osteopath was involved. Under an agreement among the medical staff, the board of trustees, and the osteopath, the osteopath will be permitted to admit patients to the hospital and treat them there under certain stipulated conditions: He may "care for nonoperative obstetrical cases and may repair injuries coincident with childbirth." Settlement of this controversy ended nearly two months of conferences and meetings between the trustees and medical staff. Under the terms of this agreement, of course, the hospital is not eligible for registration by the A.M.A. or for membership in the A.H.A.

From the hospital standpoint, it appears that the osteopathic situation is becoming a point of contention in such states as Michigan, Wisconsin, Kansas, California and Missouri, as well as Iowa. In Missouri, for example, the law reads: "Osteopaths are licensed to practice osteopathy as taught at the Kirksville School of Osteopathy." I have been told that most of these osteopaths are practicing in out-state Missouri, that their strength is growing daily, and that today they practice all branches of osteopathic medicine. Two years ago, the Audrain County Hospital board of trustees, after fighting the osteopathic problem for many years, asked the circuit court of Audrain County for a ruling on whether tax-supported hospitals must admit osteopaths as well as medical doctors to their staffs. The court ruled that all tax-supported institutions must admit osteopaths to their staffs. This case was referred to the St. Louis court of appeals by the hospital and the Missouri State Medical Association.

In a decision published last December, the court of appeals held: (1) that the hospital rule excluding osteopaths from practicing was "illegal, unreasonable, discriminatory, void and of no force and effect"; (2) that osteopathic physicians and surgeons are "physicians and surgeons within the meaning of the Missouri statutes regulating their practice rights," and (3) that osteopaths may take their patients to the hospital for treatment, "subject to reasonable rules and regulations promulgated by the board of trustees of this hospital." In its statement, the appellate court took note of the fact that 21 per cent of physicians practicing in Missouri are osteopaths.

Since this decision was handed down, the state medical association has asked for a rehearing before the appellate court. If the rehearing is denied, the motion requests that the case be transferred to the state supreme court. But, "I do not see how the supreme court can do otherwise than render the same decision as the two lower courts," Mrs. Irene McCabe, executive secretary of the Missouri Hospital Association, said recently.

ONE DOCTOR'S OPINION

PRESENTING what he made clear were his own personal impressions and opinions, Dr. Walter E. Vest of Huntington, W. Va., president of the Federation of State Medical Boards, addressed the 1953 Congress on Medical Education and Licensure on "The Osteopathic Problem." Following are excerpts from Dr. Vest's paper:

"On one hand, we have a group claiming equal rights and privileges with another group, and struggling to attain that equality without complying with the legal standards imposed on the other group. On the other hand, the opposite group, at least 10 times as numerous as the first group, demands the same standards and the same examinations for equal rights and privileges. To say a medical licensing board and an osteopathic licensing board can have equal authority and issue certificates of licensure on behalf of the state to do exactly the same things with exactly the same rights, privileges, duties and obligations is not only illogical but cumbersome, overlapping, uneconomical and just ordinary nonsense. Plain common sense demands one licensing board, one set of standards and one examination when the licentiates as individuals are to be on a par with one another.

"A large majority of present recruits to the osteopathic profession make the best possible use of the educational facilities available to them and really try to do a good job. Most endeavor to shake off the shackles of cultism and follow the paths of experimental scientific demonstration. In actual medical practice they adopt the procedures of regular medicine.

DOCTORS SHOULD HELP

"The objective of licensure of all the healing art is to ensure adequate medical care for the general population. Doctors should at least offer to help the osteopaths attain scientific medicine and more adequate training.

"Osteopathic schools have forsaken the 'cult' concept of education and have adopted the scientific concept of experiment and proof of results. These schools now approximate the unapproved [medical] schools of a third of a century ago. Chief weaknesses are lack of sufficient equipment and inability to secure satisfactory teaching personnel, especially in the basic sciences. Despite these, a number of their recent graduates have fairly good training.

"What is an equitable basis for beginning integration? First step should be

ON "INTEGRATION"

composite boards. These could have osteopathic representation in about proportion to the numbers of osteopaths and doctors of medicine licensed in the state when a composite board is formed and should blanket all practitioners licensed at the time. Subsequent applicants should be licensed to practice medicine and surgery in all branches, with equal rights and privileges, on the basis of satisfactory grades achieved on the same examination. Those candidates wanting to practice osteopathy without prescribing drugs and/or surgery should be so licensed after passing an examination in basic sciences and osteopathy alone, the latter being given entirely by the osteopathic members of the board. Licensure by endorsement of credentials should be discretionary and only on basis of full licensure to practice medicine and surgery achieved by examination except in the case of osteopaths desiring to practice without drugs and/or surgery.

POSTGRADUATE TRAINING

"The next step, which should follow immediately, should be the admission of those osteopaths with full medical licensure to postgraduate training in regular medicine and eligibility to apply for membership in the county medical societies.

"Next step in full integration should be inspection and grading of the osteopathic schools by the Council on Medical Education and Hospitals. Simultaneously with permission for inspection, the doors should be opened to these schools to obtain teaching personnel from the regular profession and an earnest effort should be made by medicine to help raise their standards and work, especially in the basic sciences. When an osteopathic school is classified as an acceptable medical school by the council, matriculants should be given the choice of graduating with degree of doctor of osteopathy or of medicine.

"Full integration necessarily is an evolutionary process and will require a long time. A chief difficulty will be overcoming the prejudices of diehards in both groups. But the osteopaths are here and they present a definite problem. It is obvious that they actually are trying to move into scientific medicine. It would be better for them, for the doctors of medicine, and the populace generally to lend them a 'helping hand' rather than force them to 'creep, and intrude, and climb into the fold.'"

"Our officers are deeply concerned over the prospect of approximately 25 hospitals in this state losing their membership in the American Hospital Association, as well as their accreditation by the new joint commission. Most of the hospital boards concerned in the state of Missouri have told me that their hospitals will comply with the law as interpreted by the court and permit osteopaths to admit patients.

"Certainly all of us are concerned with raising standards of hospital care," Mrs. McCabe concluded, "but those of us who live where such laws are on our books are faced with the problem of complying."

Replying to a question raised during this year's conference of hospital association officers, Dr. Charles Letourneau of the A.H.A. staff pointed out that the Missouri decision does not prevent a hospital board from excluding an individual physician or osteopath from practicing in the hospital, but makes it plain that any such exclusion must be based on individual qualifications and must not reflect discrimination against practitioners of any "recognized school." This same point was emphasized at the fifty-sixth annual convention of the American Osteopathic Association at Atlantic City in July 1952, where a resolution was adopted protesting that no public hospital rule is "reasonable or in the public interest [if it] excludes physicians or surgeons of the osteopathic school of medicine solely because of the school of medicine to which they belong." A spokesman of this association further related that osteopaths "are licensed and permitted to practice in all 48 states." The purpose of the resolution was to back up state and local associations in communities where osteopaths are still excluded from public hospitals, he added. Osteopaths in Michigan, however, were set back on their resolutions last November when voters in Bay City, by a 3 to 1 referendum vote, defeated a proposed amendment to the city charter which would have allowed osteopaths to practice at Bay City General, an approved municipal institution. The vote culminated a two-year battle in Bay City.

The trend in medical practice in recent years has been toward specialization, with fewer and fewer graduates of medical schools going into general practice. This means that communities under 20,000 inhabitants, which rely largely on general practitioners, may easily become short of medical doctors. As the older doctor retires or dies, it has been found in many such communities in this area, the osteopath is moving in to establish his practice. Moreover, the osteopathic colleges are graduating more and more practitioners each year. Finally, under the existing draft laws some medical doctors are being drafted out of rural areas, even before they establish their practices, while osteopaths are exempt except, of course, under the general draft laws.

Some authorities are saying that the trend toward specialization is reversing itself and that more medical school graduates are going into general practice. From statistics compiled by the college of medicine of the State University of Iowa, however, it was found that in 1940, 48 out of 70 graduates went into general practice. In the class of 1950, only 17 graduates were classified as general practitioners. On this evidence, at least, the trend toward specialization has not reversed itself. At the same time, the osteopathic schools are graduating their largest classes: There were 426 osteopathic graduates in the United States in June 1952, and this year's class, it is estimated, will reach a record 460.

Moreover, the educational requirements for osteopaths have changed in recent years. An editorial by Vincent T. Williams, M.D., editor of the *Jackson County Medical Society Bulletin* of Kansas City, Mo., dated Jan. 26, 1952, discusses the curriculum of osteopathy schools and shows how some of them compare with a recognized college of medicine: "Are osteopaths studying the right subjects and enough hours to be practicing medicine and surgery (the same as M.D.'s), which they are doing right now?" the editor asks.

The editorial then refers to a communication from the Wisconsin State Board of Medical Examiners to the president of the State Medical Society of Wisconsin, as published in the *Wisconsin Medical Journal* for December 1951, including information on hours of study in osteopathic schools and grades made by physicians and osteopaths on state board examinations (see tables).

"If one looks over this table (Table 1) without having a preformed idea, the answer is obvious," the *Bulletin* editorial continues. "But, he might say, just putting in so many hours of

Table 1—Hours of Study

Kirksville College of Osteopathy			
Pharmacology and Materia Medica			126 hours
Los Angeles School of Osteopathy			
Pharmacology and Materia Medica			288 hours
Kansas City College of Osteopathy			
Pharmaco-Dynamics		120 hours	
Materia Medica and Prescription Writing		36 hours	
Clinical Pharmacology		48 hours	
Applied Pharmacology		54 hours	358 hours
Chicago College of Osteopathy			
Pharmacology			190 hours
Philadelphia College of Osteopathy			
Pharmacology and Materia Medica			180 hours
University of Wisconsin			
Materia Medica	Lecture	64 hours	
	Lab	48 hours	112 hours

inferior training doesn't prove anything. What about the other subjects studied? There is a lot of truth in such a contention. But let's look again at the proof of the pudding from the *Wisconsin Medical Journal*.

"The accompanying table (Table 2) is an interesting comparison of respective grades compiled, showing the grades received by the first five osteopathic candidates who were examined in July 1951 and the grades received by the first five medical applicants examined at the same time by the Wisconsin State Board of Medical Examiners.

"Probably it is best for each reader to make up his own mind on what inferences may be drawn from the facts presented."

The public pressure which is brought to bear on hospital boards of trustees to accept osteopaths must also be considered. Another point which affects trustee thinking is the financial status of the hospital. In some communities there are as many osteopaths as there are doctors of medicine. The experience may be that the osteopaths are taking their patients to another hospital in the same or a near-by community where they have staff privileges, with a consequent loss of dollar business to the local hospital. These may appear to be minor problems, but in a small community they can be problems which demand attention and solution by the hospital board.

It can't be denied that the osteopaths have established their practice in society and are giving medical attention to an appreciable segment of the population. In some cases, osteopaths are accepted in certain sections of the health field, such as state licensing boards, state hospital advisory councils, social welfare agencies, and others. Blue Cross and insurance companies in some areas make no distinction between osteopaths and medical doctors, or between their hospitals. "It appears that the absorption of osteopathic colleges and graduates into a general medical field is now coming about," a committee of the Wisconsin State Medical Society council reported two years ago. "The process should not only be orderly but in the interests of public health protection." Wrestling with the licensure problem there at about the same time, a member of the state board of medical examiners wrote a friend that "this whole matter . . . has been one of the worst headaches that this board has had. . . . Every member has tried to lay aside any personal prejudices that he may have had and has attempted to enforce the law in accordance with the interpretations that have been put upon it."

Some authorities have intimated in the past year that some of the differences between medical doctors and osteopaths may eventually be ironed out. It has often been suggested, for example, that osteopathic medical schools should be encouraged to appoint professors on their staffs from Class A medical colleges. As noted an authority as Dr. Malcolm T. MacEachern of the A.H.A. staff has stated that he did not think it was necessary for state hospital associations to take a positive position in this matter; with the medical profession putting its own

(*Continued on Page* 150)

Table 2—WISCONSIN STATE BOARD OF MEDICAL EXAMINERS
Report of Examination at Milwaukee in July 1951

No.	Chem.	X-Ray	Bact.	Ped.	Med. Juris.	Diet.	P. and P. of Med.	Phys.	Mat. Med.	Tax.	Phys. Diag.	Neur.	Hyg.	Anat.	E. E. N. and Throat	OB.	Gyn.	Surg.	Path.	Practical	Gen. Ave.
Marks of first five M.D.'s examined in July 1951																					
1	80	90	86	85	83	90	80	80	85	80	82	86	90	92	88	91	90	86	80	85	85
2	83	84	78	82	85	80	80	78	80	70	85	80	90	92	82	89	95	90	86	80	83
3	85	86	80	88	88	90	80	80	90	70	80	85	88	90	82	91	89	85	85	88	85
4	88	87	85	88	82	77	80	80	82	75	85	80	85	93	81	90	92	80	90	80	84
5	92	92	88	90	88	88	85	80	88	72	88	90	88	88	88	89	93	88	92	75	87
Average, M.D.'s	85.6	86.6	83.4	86.6	85.2	85.0	81.0	79.6	85.0	73.4	84.0	84.2	88.5	90.1	84.2	90.0	90.5	85.8	86.6	80.4	80.4
Marks of first five D.O.'s examined in July 1951																					
1	83	88	80	81	80	83	80 86	80	83	70	83	86	85	81	82	94	94	85	85	88	83.7
2	83	84	85	90	77	75	85 80	80	75	70	80	77	80	83	88	87	93	92	86	80	82.4
3	84	88	88	70	85	80	80 85	78	90	70	82	80	90	82	93	88	92	88	82	85	83.8
4	89	90	90	84	80	75	78 90	90	87	70	90	90	90	82	92	92	93	89	92	89	86.8
5	90	93	92	75	80	85	90 85	80	86	73	90	90	86	82	91	90	94	93	88	90	86.8
Average, D.O.'s	85.8	88.6	87.0	80.0	80.4	79.6	85.2	80.4	84.2	70.6	85.0	84.6	86.2	82.0	89.2	90.4	93.0	89.4	86.6	86.4	84.7

MAIN ENTRANCE TO JANE G. PHILLIPS MEMORIAL HOSPITAL, BARTLESVILLE, OKLA.

THE MODERN HOSPITAL OF THE MONTH

Bartlesville Is Prepared for Polio

ARTHUR E. COLTRIN
Administrator
Jane G. Phillips Memorial Hospital
Bartlesville, Okla.

HOMER F. NEVILLE
Architect
Neville, Sharp and Simon
Kansas City, Mo.

THE Jane G. Phillips Memorial Hospital, Bartlesville, Okla., completed in November 1952, held open house to 12,000 people of Bartlesville and surrounding areas of northeastern Oklahoma who came to pay their respects to the memory of Mrs. Frank Phillips and view one of the most modern hospitals in the Southwest. The hospital is located one and a half miles east of Bartlesville on an 11 acre tract in a new residential area overlooking a small lake to the south and the city on the west. This quiet, scenic site minimizes the ever increasing problem of parking and expansion of facilities for a rapidly growing community.

Funds for the hospital were provided by the Frank Phillips Foundation.

Bartlesville, a city of 19,228 population (1950 census), has within a five-mile radius 27,000 of the county's 32,800 residents. It boasts of being

Left: Corridor between living room and bedroom in suite. Bathroom is off passage to right. Corridor leads into living room shown below.

Above: View of the main lobby. Below: Large ward for convalescent polio patients. Respirators were on display for visitors during open house.

Isolation ward for polio cases.

"America's Ideal Family Center" and its high per capita income is due largely to its industrial, farming and cattle activities. Bartlesville, the county seat of Washington County, which encompasses 272,000 acres, already supports a county hospital of 130 beds, thus giving the area an enviable ratio of hospital beds of 5.7 per thousand. The drawing area for general hospitalization is approximately 40,000 population but much larger for polio care.

The Jane G. Phillips Memorial Hospital, with a normal occupancy of 100 beds, is of the conventional reinforced concrete construction used in completely fireproof buildings. Floors are of the joist and slab type with suspended plaster ceilings, and the exterior walls are of face brick backed up with hollow tile. Interior partitions are of red clay tile, generally, and covered with sand finished plaster except that in areas where frequent washing is anticipated smooth plaster was used. Semigloss enamel paint was used almost throughout.

The windows are all of aluminum with a bottom, hopper type of ventilating section only, inasmuch as the building is completely air conditioned.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

The louvered sunshades above the windows are of redwood; sills, copings and a small amount of trim are of cut limestone.

The main kitchen and certain service areas have walls of structural glazed tile with quarry tile floors, while service kitchens, nurses' utility rooms, operating and delivery rooms, and the like have ceramic tile walls, and the floors are of either tile or carbon conductive terrazzo. Corridor wainscots, 5 feet high, were made of a plastic coated fabric of the kind often used in upholstery to simulate leather. Color is used extensively in the corridors and throughout the hospital.

Doors throughout are of the solid core wood, flush type, in natural birch finish. Door frames and trim are of steel. The corridor floors are of rubber tile while patient room floors are of asphalt tile, with bases of the same two respective materials. A projecting concrete base covered with vinyl plastic was installed on the bed wall of the patients' rooms to prevent this wall from being damaged by the furniture.

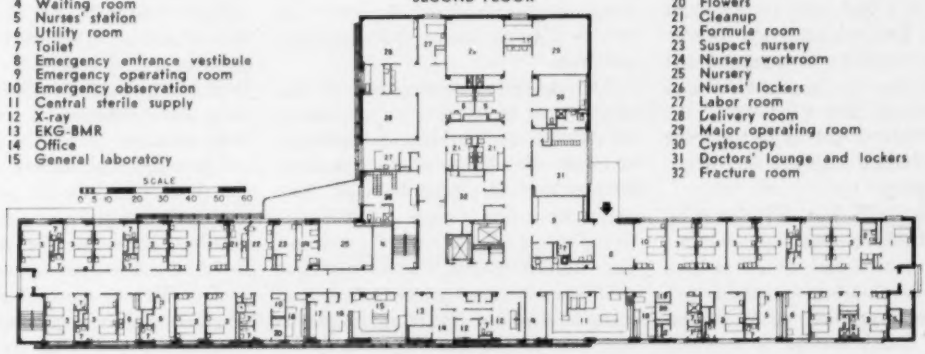
Each room is equipped with lights and outlet for two beds, but some are

Above: Exercise space in the physical therapy department. Below: The corridor of the operating suite. Cystoscopy room is shown at right.

KEY TO SECOND FLOOR

1 Sitting room
2 Bath
3 Patient's room
4 Waiting room
5 Nurses' station
6 Utility room
7 Toilet
8 Emergency entrance vestibule
9 Emergency operating room
10 Emergency observation
11 Central sterile supply
12 X-ray
13 EKG-BMR
14 Office
15 General laboratory
16 Washing and sterilizing
17 Pathology
18 Pantry
19 Linen
20 Flowers
21 Cleanup
22 Formula room
23 Suspect nursery
24 Nursery workroom
25 Nursery
26 Nurses' lockers
27 Labor room
28 Delivery room
29 Major operating room
30 Cystoscopy
31 Doctors' lounge and lockers
32 Fracture room

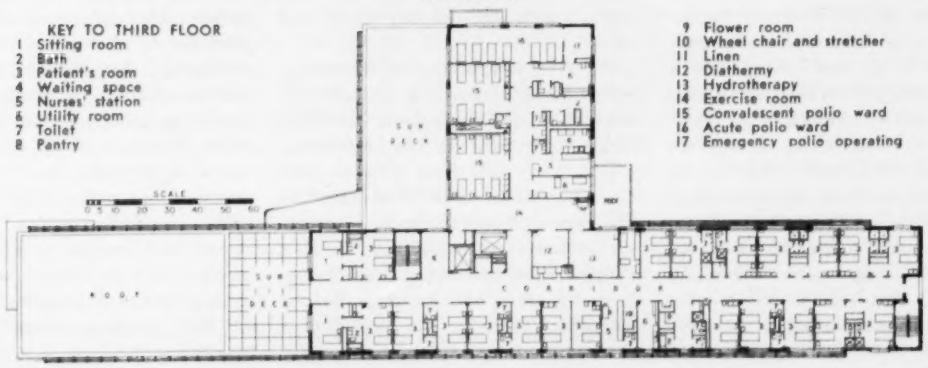
SECOND FLOOR



THIRD FLOOR

KEY TO THIRD FLOOR

1 Sitting room
2 Bath
3 Patient's room
4 Waiting space
5 Nurses' station
6 Utility room
7 Toilet
8 Pantry
9 Flower room
10 Wheel chair and stretcher
11 Linen
12 Diathermy
13 Hydrotherapy
14 Exercise room
15 Convalescent polio ward
16 Acute polio ward
17 Emergency polio operating



The soda grill and gift shop. Snack service is also available on the terrace.

OUTLINE OF COSTS

Total project cost including boiler house, laundry and passage and Group I equipment	$1,661,943.15
Groups II and III equipment	201,148.67
Cost per bed	18,630.91
Cost per square foot	29.32
Cost per cubic foot	1.97
Total square foot area including power plant and laundry	63,541
Square foot area—hospital only	57,756
Square foot area per bed	577

furnished for only one patient. All rooms have combination direct and indirect light fixtures over the beds but no center light fixture, two built-in metal wardrobes, oxygen outlets, a night light, nurses' call button and light over the corridor door, as well as a nurse-to-patient speaker system and a heating and air-conditioning unit. With the exception of a very few rooms, all have a lavatory, toilet and shower. Three suites are provided consisting of a bedroom, sitting room and private bath with tub and shower. The sitting rooms are so arranged that if necessary they can be converted into patients' rooms. The windows in the patients' rooms as well as in the work areas are covered with sill length traverse draperies.

The soda grill just off the main lounge and offices serves light lunches and offers small items which patients or visitors may wish to purchase, such as cosmetics, magazines, candy, flowers and gifts. Snack service is available either in the grill or on the adjacent terrace. The pharmacy, under the supervision of a registered pharmacist, in addition to the usual dispensing of drugs, is equipped to do considerable manufacturing, including solutions. The solution room, where all stills for the hospital are located following the new concept in water sterilization, is immediately adjacent to the pharmacy and is in direct connection with the central sterilizing room above by means of a dumb-waiter. The boiler house and laundry building was built at a distance from the hospital because of the noises and odors produced by its equipment but is reached through an enclosed passageway from the main building. It provides a central service of supply for hot water heat, hot water, softened water and chilled water for air conditioning; it also houses pumps, compressors, transformers, emergency lighting equipment and ventilation controls. Oil is used to fire the boilers and electrical energy is purchased. The laundry is the conventional small laundry which takes care of the hospital linens and employes' uniforms.

The operating room suite on the second floor of the hospital is planned for the ultimate expansion to 200 beds, as were the boiler house, laundry, kitchen and all piping services. Two major operating rooms and two delivery rooms, together with cystoscopy, and fracture rooms, are its principal elements. Patients' rooms for surgical cases adjoin the operating rooms on one half of the same floor, and maternity rooms are on the other half together with the delivery rooms and nursery.

A fortunate condition of the topography made it possible to have the emergency and ambulance entrance widely separated from the visitors' entrance and up one floor, close to other operating rooms. It will be noted on the plans that ground level advantages are available on two floors. Doctors may use either entrance and registering-in boards are at both locations, but the emergency entrance will probably be the one most used owing to its proximity to the doctors' lounge. At the intersection of these critical areas, the operating rooms, delivery rooms, and emergency, are the auxiliary departments that are a necessary adjunct to functional operation; central supply, x-ray, pathology and laboratories are no further than a few steps from the areas they serve.

Food service is centralized and conveyed by means of heated and refrigerated carts especially designed by the architect and staff. An adapted airline type of service to afford the maximum portion and temperature control has been inaugurated. No food other than soup and beverages is served in the floor pantries.

There are two nursing divisions on the third floor, one for general medicine and a wing directly above the operating rooms for the treatment of both acute and convalescent polio patients. Because of the high incidence of poliomyelitis in this section of the state for several years there has been considerable need for beds of this nature. The only wards in the hospital are in this wing because it is anticipated that most of the patients will be children. A small polio emergency operating room is provided adjacent to the ward for acutely ill patients. In this wing also is the physical therapy department, with its exercise space, hydrotherapy and diathermy rooms and service facilities all adjoining the convalescent patient wards. A large sun deck on the southeast side of the building connects to these spaces.

Job descriptions showing precisely who does what under whose supervision, plus the proper preparation for each job, are Huntington Hospital's answer to the expanding nursing needs and the increasingly obvious fact that—

ONE NURSE can't do EVERYTHING

DE LORES J. SCHEMMEL, R.N.
Director of Nursing
Huntington Memorial Hospital
Pasadena, Calif.

RECENTLY Mrs. X, the wife of a prominent physician and a former head nurse in a large metropolitan hospital, had the opportunity of observing closely the activities of today's nursing service in our institution as her husband was hospitalized for a brief period.

After this experience, Mrs. X phoned me and said, "I did manage to learn in five days while visiting the hospital the difference between the various types of workers in the nursing service department by the colored uniforms, but it must be terribly confusing, and how do you differentiate between the functions of vocational nurses and other auxiliary nursing personnel with lesser training? In my day, that is the depression era, it seemed much less complex!"

Mrs. X is right. Nursing service, like all other professions, government services, and industry, has gradually grown in complexity during this last decade. The nursing services demanded by the people of this country have expanded so greatly that a variety of nursing personnel is needed to meet these demands. Gone are the days when just one level of nurses with one type of preparation could perform all of the nursing functions for our patients.

QUESTION OF PROPORTION

"The basic controversy evaporates and differentiation becomes a necessity from the point of view of available human resources as well as prospective work if nursing is regarded as what it has actually become through force of circumstances, namely, a broad occupational field requiring large numbers of different types of personnel with varying kinds and amounts of preparation for a wide range and variety of essential functions. The question becomes one of proportionate numbers in various categories with equal emphasis upon preparation for competency at every level and of every kind."[1]

How many categories of workers should we use in hospital nursing service? What proportionate numbers should we employ in each category? Do we have appropriate programs for the preparation of each group of workers? And, how are we going to establish a working relationship using a variety of personnel with varying kinds of preparation, encouraging workers to perform at their highest potential, thereby ensuring safe, competent and economical care to our patients and work satisfaction to our nursing personnel? These are questions facing the nursing profession today.

The gamut of nursing activities is now so long—and tomorrow it may even be longer and more varied—that several types of nursing service personnel are evolving, functional analysis studies are under way, and experimental programs are moving into action. Introducing ancillary personnel

[1]Dean Margaret Bridgman, Collegiate Education for Nursing, Russell Sage Foundation, January 1953, p. 18.

JOB DESCRIPTIONS

GENERAL CLERK

DEPARTMENT: Nursing

SUMMARY OF DUTIES:

Performs a variety of routine clerical duties which may include: sorting, filing, setting up material, such as records, charts, charge tickets, letters. Tabulating and/or compiling such data as routine charges nursing ratio hours, medical charts, dismissals, TPR's.

May answer personal and telephone inquiries, making referrals, recording messages, giving information. May assist other activities by running interdepartmental errands, sending telegrams, making menus, assisting with dismissal of patients.

May be required to type routine letters, memorandums, notes, and use duplicating machine. Performs other related duties as necessary.

SUPERVISION RECEIVED:

Receives moderate operational guidance from immediate superior.

PRACTICAL NURSE

DEPARTMENT: Nursing

SUMMARY OF DUTIES:

Performs several or all of the following duties:
Administers general care to patients, including oral hygiene, baths, toilet care, back rubs, cold and hot packs, lavages and gavages, and assists with general care of newborn. Assists with keeping patients comfortable, lifting patients and equipment, serving food trays. Responsible for charting care personally administered.

May assist with preparing formulas for newborn, which includes weighing and measuring ingredients, following sterile procedures. Runs errands to pharmacy, central supply, fountain.

Assists in maintaining orderliness and cleanliness of patient's room, nursing station, utility room and kitchens. Cleans floor utensils and sterilizes when necessary in utility room's sterilizers.

Performs other related duties as necessary.

SUPERVISION RECEIVED:

Receives moderate operational guidance from head nurse and/or team captain.

WARD MAID

DEPARTMENT: Nursing/Housekeeping

SUMMARY OF DUTIES:

Performs part or all of the following routine activities: Dusting, polishing, scouring hospital furniture, bathrooms, floors, kitchens; gathering, washing, sterilizing and storing floor nursing utensils and equipment. Distributes ice, linen and utensils to patients' rooms. Performs other related duties as necessary.

SUPERVISION RECEIVED:

Receives moderate operation guidance from head nurse or assistant housekeeper.

NURSE'S AIDE

DEPARTMENT: Nursing

SUMMARY OF DUTIES:

Assists with general patient care, which includes: giving baths, back rubs, toilet care, cold and hot packs, serving food trays and ice water; making beds, and keeping patient comfortable by straightening bedding and lifting patient.

Assists in maintaining orderliness and cleanliness of utility rooms and kitchens.

Cleans floor utensils and equipment and sterilizers when necessary in utility room sterilizers. Runs errands to pharmacy, central supply. Performs other related duties as necessary.

SUPERVISION RECEIVED:

Receives moderate guidance from head nurse and/or team captain.

WARD AIDE

DEPARTMENT: Central Supply

SUMMARY OF DUTIES:

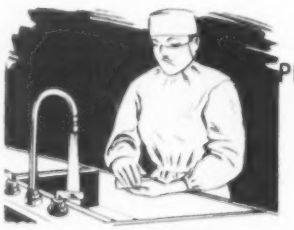
Performs any or all of the following routine activities:
Checks, keeps current, and maintains at minimum level supplies on hand. Makes up, autoclaves, stores and dispenses dressing packs, linen, drainage sets, catheterization trays, hypodermic syringes, needles.

Cleans, stores soiled instruments, utensils and equipment; may deliver equipment and supplies requested by the floors and returns soiled central supply utensils. May wash, dry, test, powder and pack hospital surgical gloves.

Issues and records equipment loaned; dispenses I.V. sets and solutions ordered. Receives and records messages for orderlies. Helps to maintain the cleanliness of the department. Performs other related duties as necessary.

SUPERVISION RECEIVED:

Receives general operational guidance from head nurse of central supply.



PRACTICAL NURSE — SURGERY

DEPARTMENT: Nursing

SUMMARY OF DUTIES:

Acts as "circulating nurse" with the exception of sterile preparation and technics. Assists with preparing operating room and does postoperative clean-up. Cleans operating tables, floor bucket stands, blanket warmers.

Performs workroom procedures of folding linen, powdering gloves, assembling surgical packs. May give preoperative preparation to female patients. Assists with returning patients to rooms. Performs other related duties as necessary.

SUPERVISION RECEIVED:

Moderate operational guidance from clinical instructor of surgery.

in our nursing service departments brings up new problems. This seems to be one of the laws of nature: we solve one group of problems but, in doing so, create a new group of problems. It is not uncommon to hear hospital and nursing executives stress the need for differentiation of the functions of practical or vocational nurses with a year or more of training and aides with less training. It is equally common to hear the need stressed for differentiation of the duties of vocational nurses with a year of preparation and the registered nurses who have had at least the traditional three years of preparation.

IT'S NOT THAT SIMPLE

We somehow have the idea that if we set up a clear "functional" list of duties representing a distinct cleavage between the various categories in nursing our nursing service problems would lessen. We could then use the assembly line technic for service something like the "wash-a-teria," sometimes called the "minute wash"—where the first man directs the car line; the second vacuums the seat and floor of the machine; the third soaps the chrome; the fourth washes the car body; the fifth dries the machine, while the last man does the polishing. Unfortunately, giving good nursing care isn't that simple because our product is a specialized personal service to people and not inanimate things—the people whom we serve represent a wide distribution in the types of disease, degrees of illness, and range of emotional factors involved.

Early in 1948 Huntington Memorial Hospital, Pasadena, Calif., offered seven and one-half months of clinical practice experience to the students of Pasadena City College's vocational nursing program, the first program of its kind to receive national accreditation on the West Coast. Since the inception of this program, we employ as many vocational graduates as are available. When the program began, we encouraged many aides who were on our nursing staff to take the vocational course. We now endeavor to employ only vocational graduate nurses from accredited programs; however, we employ applicants who we think have comparable preparation and experience but encourage them to take the state vocational nurse examination. This gives them vocational nursing status and the privilege of wearing the gray uniform, plus the salary compensation of this personnel category.

For specific duties of a routine nature, such as central supply room work where a corps of personnel prepares and dispenses supplies and equipment, we use the untrained aides and give them on-the-job training to prepare them to do a specific job. All of the aides, whether they are employed for central supply room work, operating room supply room, delivery supply room, or work on the nursing service units, wear blue and white pinafores, and are compensated according to the classification as set up for this category of personnel.

A third category of ancillary workers in the nursing service department are the general clerks, usually referred to as the ward clerks. Since the work of these employes is clerical in nature, they wear street clothes with a short white smock which not only identifies them as official workers on the unit, but protects their clothing. Nearly all of our general clerks have had some business experience before being employed in our institution. Each new clerk receives one week of intensive training on the job, learning not only what to do, and how to do the job, but why it needs to be done a certain way. This training is under the direct supervision of a senior clerk who is specially prepared and trained to do this teaching job. The program was set up by our in-service committee and is supervised by an in-service instructor.

The orderlies constitute the most heterogeneous group and the least stable inasmuch as most of the personnel in this category use the position as a stepping stone to a better position or career. Preparation for this job is given on the job and is under the direct supervision of the central supply supervisor.

PROGRAM IS NOT STATIC

At this time we hesitate to give for publication a so-called list of functions for the various personnel categories in our nursing service department because our programs of in-service education for all nursing service personnel are not static and modifications are made to keep them consistent with changing functions. For example, at the present time we have on our nursing staff a few nurse's aides who are not ready for the vocational nurse classification. Through our in-service program we are having classes to teach them to chart for the procedures and simple nursing care which they give. We are also in the process of broadening the scope of functions for our ward clerks, such as posting orders from the doctor's order sheet to the visible card files.

We believe that the important thing is that each employe within the nursing service department should know not only the functions in his own classification but how his position fits into the general established nursing service pattern of the institution. We all know that there are common elements but there are certainly some very diverse ones in the work of our aides or attendants, vocational or practical nurses, staff nurses, head nurses and supervisors. The important thing is to have an organized nursing care plan which takes into consideration the skills and preparation of the workers in the department.

It is our belief that the best way to ensure the proper utilization of personnel in the nursing department is through the team nursing plan. We instituted the team method of assignment in our institution in 1949 in the medical units, and since then we have spread it to other units. We feel this plan facilitates this important underlying principle:

"The nurse in charge of the nursing care of a patient must be responsible for the use of consultative help when needed and for carrying out procedures and treatments for which she is prepared and for assigning others in the team to nurse at a level for which they are prepared."[2]

TEAMWORK MUST BE TAUGHT

We have learned from experience that team relationships must be taught and that our team plan is as strong as its weakest link. Readers interested in this method of patient assignment will find many worth-while articles on this topic, one of the best entitled, "Planning Patient-Centered Care."[3]

In 1951 a job analysis study was made for every position in our institution. Each job description gives a summary of job duties and by comparing the various categories of workers in the nursing department, excluding the registered nurse group, one can get a general picture of job differentiation in ancillary nursing as set up in our institution.

[2]The Handbook for Team Method of Patient Assignment. Huntington Memorial Hospital.

[3]Leino, Amelia: Planning Patient-Centered Care. Am. J. Nurs. **52**:324 (March) 1952.

Eighth-Graders Set the Stage

for good public relations at Evanston Hospital

EMILY STEBBINS
Public Relations Department, Evanston Hospital, Evanston, Ill.

ALMOST six hundred students and faculty members at Nichols Intermediate School, Evanston, Ill., a hospital audience of more than 200, and the community of Evanston through its local news magazine, the *Evanston Review*, have a new understanding of Evanston Hospital as the result of a project of 28 eighth-graders in a Nichols school homeroom.

The educational policy of Evanston grade schools is to make pupils aware, through various means, of social situations in the community that are of vital importance. A member of the Evanston Hospital public relations department, therefore, suggested to the homeroom teacher and dramatic director that Evanston Hospital might be a suitable topic for an assembly program.

The children themselves made the final decision to present this social agency because, as they said in their foreword to the play, "Evanston Hospital is one of the most important buildings in town. It has touched the lives of almost every family."

To prepare for the play, the pupils did extensive research. For about a month, their teacher reports, they lived Evanston Hospital. They pored over literature about it—the monthly *Pilot* publication, "Inside Evanston Hospital," nursing school bulletins. They visited the hospital to see how various departments operated. They discussed experiences when they had been treated there.

Out of this study, with the guidance of the homeroom teacher, Mildred Milar, and the dramatic director, Mrs. Polly Lowndes, the youngsters developed a diverting, amusing and educational play which they first presented in the school auditorium to more than 550 classmates and almost 40 teachers, parents and guests.

The program was so interesting that the group was asked to repeat it for Evanston Hospital in the school of nursing auditorium. Graduate and student nurses, a group of new senior nurse's aides, technicians, therapists, executives, dietitians, maids and orderlies, even a few patients, five visiting administrators and friends attended.

Because such a project was considered "news," the *Evanston Review* ran a three-quarter page spread of pictures showing scenes from the play, and the hospital audience. A large part of the community of about 70,000 was thus reminded of the work which Evanston Hospital does.

For their play the children chose to present departments of a hospital that are oftenest seen, *i.e.* the emergency department, x-ray diagnostic department, occupational therapy, and personnel. With the skillful guidance of the two teachers they gave the human and amusing aspects of the hospital. Combined with these were such facts as "Evanston Hospital is one of few in the greater Chicago metropolitan area which treats polio during the early or acute stages of the disease. More

Children love to stick crayons up their noses, the student nurse assures a "mother" in the emergency room.

than 15,000 visits were made to the outpatient clinics in 1952. The emergency department is open day and night, Sundays and holidays, ready for any acute sudden illness or emergency."

Service was the recurring theme of the play—the service which a hospital performs for a community and the satisfaction which an employe, volunteer or professional person gains in serving there.

Significant is the fact that the children themselves composed the five-act play. From their research and experience they suggested what they thought should be told about the hospital. The teachers guided them in working out a continuity which would hold the interest of audiences. Not one word was written. Each performance had its variations, depending upon the spontaneous reactions of the actors and actresses at that moment. The same basic facts, however, were always given. Every child in the homeroom had a part in the play and now each believes that Evanston Hospital is particularly his.

The principal of the school was pleased with the program for two reasons. It developed a real interest in an important community agency. Such an interest, many educators believe, makes a child realize that he can do something constructive and creative at his own level which relates and integrates him with the life about him. He thus becomes a working force in the community, rather than a bystander who merely looks on.

Because the assembly program was taken to the hospital and a news story was written about it, the community itself was acquainted with an educational policy. Those not closely associated with the schools learned that assembly programs are teaching experiences for the audience and actors—and not designed solely for the entertainment of the pupils.

Scene in the x-ray waiting room where the "lady patient" (seated) amused the audience with a recital about her gall-bladder troubles and the lad on crutches caused a laugh with his unusual gait and his bright red sox.

For Evanston Hospital, the assembly program proved to be a far-reaching public relations project—one which told the hospital story to all ages in the community and in addition gave many employes a new undestanding of the important work which their hospital does.

In the occupational therapy scene, patients play games and do handwork, while a former patient brings a gift.

Hospitals and Insurance Industry Speak Up:

On Malpractice Liability Insurance

1. Hospitals Must Be Protected at a Price They Can Pay

HAROLD H. HINES Jr.
Board of Trustees
Michael Reese Hospital
Chicago

FROM the point of view of hospitals, the problem of malpractice liability insurance is essentially the administrative one of determining whether hospitals should bear the malpractice risk or whether they should transfer it to some agency better able to bear the risk efficiently and economically. When carefully analyzed, the problem divides into a number of issues which involve the type of hospital, its patients and doctors, the community it serves, and also the insurance companies—if they are selected to assume the risk.

HOSPITAL HAS A DUTY

As a preface to this investigation, it is appropriate to consider briefly the question of whether or not a hospital is liable for "negligence" which causes injury to its patients. Charges of malpractice are based upon breaches of duty imposed by law. The duty of the hospital is to use ordinary and reasonable care in providing medical and nursing services to the patients it accepts for treatment. Until recently, however, a principle of law was established which declared that a purely charitable institution could not be made liable in damages for the negligent acts of its employes and doctors. Were this not so, courts held, it would not be difficult to discern that private gifts and public aid would not long be contributed if their ultimate destiny was to pay for litigation. Charitable institutions of all kinds would ultimately cease or become greatly impaired in their usefulness.

Lately, this doctrine of immunity from negligence claims has been altered, although the evolution of established law is by no means complete in all states. An Illinois court, early in 1950, declared that the law is not static and must conform to changing conditions which demand that there be uniformity of liability without qualification in our society. In this state, charitable institutions are not immune from suit nor are they immune from liability for their torts. Such immunity as charitable institutions now have is only with respect to trust funds; nontrust funds of a charitable institution may be reached for satisfaction of a judgment against the charity.

This trend toward a socialization of the law, however, maintains a distinction between the various types of hospitals: public or government, private charitable, and private for profit. A charitable hospital is one which pays no dividends, has no capital stock, seeks no profits, and is *supported* in part by charitable donations. It opens its doors to all those who seek its aid, without scrutiny of the character or worth of those who need its services. Since this type of hospital represents a large portion of the medical institutions in the United States, it has been the subject of many inquiries regarding its liability for negligence. The government hospital enjoys a peculiar immunity too involved to discuss here, while the profit hospital has obligations to the public similar to those of any other private corporation.

Because of its philanthropic nature, the charitable hospital must consider some other facets of the malpractice problem beside the legal one. An institution that depends upon contributions from the community which it serves cannot ignore the damage to its public relations when it refuses to compensate persons injured as a result of its negligence. This, plus the moral obligation of the nonprofit hospital to relieve its patients from all constraint, demands that the hospital do everything it can to assist individuals injured as a result of its lack of prudence to attain a full life. If the hospital first agrees that these are important considerations, then it must decide whether it wants to meet these obligations itself or transfer them to some other agency.

NATURE OF THE RISK

Before the methods of meeting the malpractice risk are developed, it might serve a useful purpose to outline the nature of the risk. In its technical sense, risk means the uncertainty of the occurrence of an undesired event involving definite financial loss. The variety of allegations which patients may use to bring charges of malpractice against hospitals makes it difficult to study the risk involved. The type of disease treated definitely conditions the quantity of risk. Surgery presents more claims than medicine does. Diseases requiring long confinement, or impairing the patient's normal capacities, involve added hazard. Additional

dangers arise with the therapeutic use of dangerous physical or chemical agents, particularly x-ray equipment and radium. Finally, there is the risk involved in the amount of experimental or investigative research practiced on patients.

The first step in meeting the malpractice risk seems to be a careful study of the risk factors in the internal operation of the hospital to determine significant measures to reduce them. Elimination of the hazard is one of the most fundamental means available for reducing the malpractice risk, and often it is the most neglected. An inquiry into past experiences within the hospital with regard to accidents to patients and their resulting claims—both actual and threatened—may indicate current practices which are conducive to more claims. Examination of data derived from other hospitals may suggest other possible ways of avoiding future trouble.

An analysis of the relative distribution of malpractice claims indicates that burns, drugs and ice packs account for about one-quarter of all claims. Surgical operations, including anesthetics and hypodermic injections, are the next most frequent basis for claims, while wrongful diagnosis, self-inflicted injury, and x-ray or radium treatment are prominent causes of suits.

When a study of the malpractice experience of the individual hospital is made, certain things which are amenable to administrative control will be revealed. The selection, training and supervision of hospital personnel is an obvious consideration. If it is not prohibitively expensive, an attempt to centralize personnel supervision and control with an eye to attracting the most desirable unskilled labor should be made.

REDUCE CAUSES FOR CLAIMS

Another controllable factor is the professional staff. Physicians and surgeons should be familiar with the causes of malpractice claims so that they can be alert to the program of reducing them. They should avoid any comment which may provoke an unfavorable interpretation by the patient of the care received in the hospital; for, strange as it may seem, a significantly large number of cases originate with a careless word or action of a doctor. Nurses must also cooperate to reduce the malpractice hazard. There are two essential elements which are significant in considering the malpractice risk from the nursing aspect. One is the proportion of graduate nurses in relation to student nurses and aides, the other is the supervision of nursing operations and performance. Attention to these factors will have a positive influence on reducing claims.

It is the task of the hospital administrator to determine what proportion of the malpractice risk the hospital will bear, what portion it will attempt to eliminate, and what portion it will transfer to professional risk bearers. As has been mentioned, the hospital can no longer bear its own risk with the idea that it can legally defend itself against liability suits. The "trust fund" theory has been modified to a point where there is no absolute immunity from judgment in favor of charitable institutions. Furthermore, it should be added that the nonprofit hospital can no longer claim that it is not responsible for the wrongful acts of its physicians, nurses, technicians or other employes. The courts now hold that the complexities of modern hospital care have created a case which did not formerly exist and that, even though the hospital receives no profit or advantage to itself from what its personnel does, it must be responsible for its acts.

Hospitals formerly assumed their own malpractice risk with the thought that one who becomes the beneficiary

(*Continued on Page* 140)

2. "The Insurance Industry Is in the Squeeze"

DON C. HAWKINS
St. Paul-Mercury Indemnity Company,
St. Paul

THE casualty insurance industry finds itself caught today in the multi-sided squeeze of rampant inflation, socialistic trends, excessive claims, and inadequate rates. It is no longer a secret that casualty insurance companies have been losing heavily on liability insurance. In the single year 1951 the stock companies alone suffered an underwriting loss of more than $100,000,000. Their aggregate underwriting losses on automobile liability insurance for the six-year period 1946-51 exceeded $200,000,000. Less well known is the fact that workmen's compensation insurance, another large and important line, moved into the loss column several years ago, and is still there. The National Bureau of Casualty Underwriters reported for the year ending Dec. 31, 1951, that all companies entered to write casualty and surety business in the state of New York suffered a net underwriting loss for all lines of $91,307,093. In other words, these companies, which write a majority of our business nationwide, went in the red $91,307,093 on their underwriting experience.

In order to understand the condition that led to these losses, however, we must consider what has been happening in the two biggest casualty insurance fields—workmen's compensation and liability. These two lines are the biggest and they command by far the most public interest.

Unlike most other businesses and industrial enterprises, insurance companies are not permitted to increase their rates at will to meet rising costs of doing business. They have long been regulated by state governments, and their rates—that is, sale prices—must stand the test of governmental approval. Therefore, confronted by rapidly increased losses with no prospect of improvement in the foreseeable future, they have filed new rate schedules with the state supervisory authorities, in the hope that the new rates will be sufficient to take them out of the red and allow a small margin of profit.

From the facts and figures, all of which are a matter of public record and readily available for confirmation, one might suppose that there would be no question about insurance companies being granted the rates they need to earn at least a small profit. On the whole, I believe, state supervisory authorities are inclined to grant some increases—not as much as the

(*Continued on Page* 144)

Condensed from an address presented to the Illinois Hospital Association, November 1952.

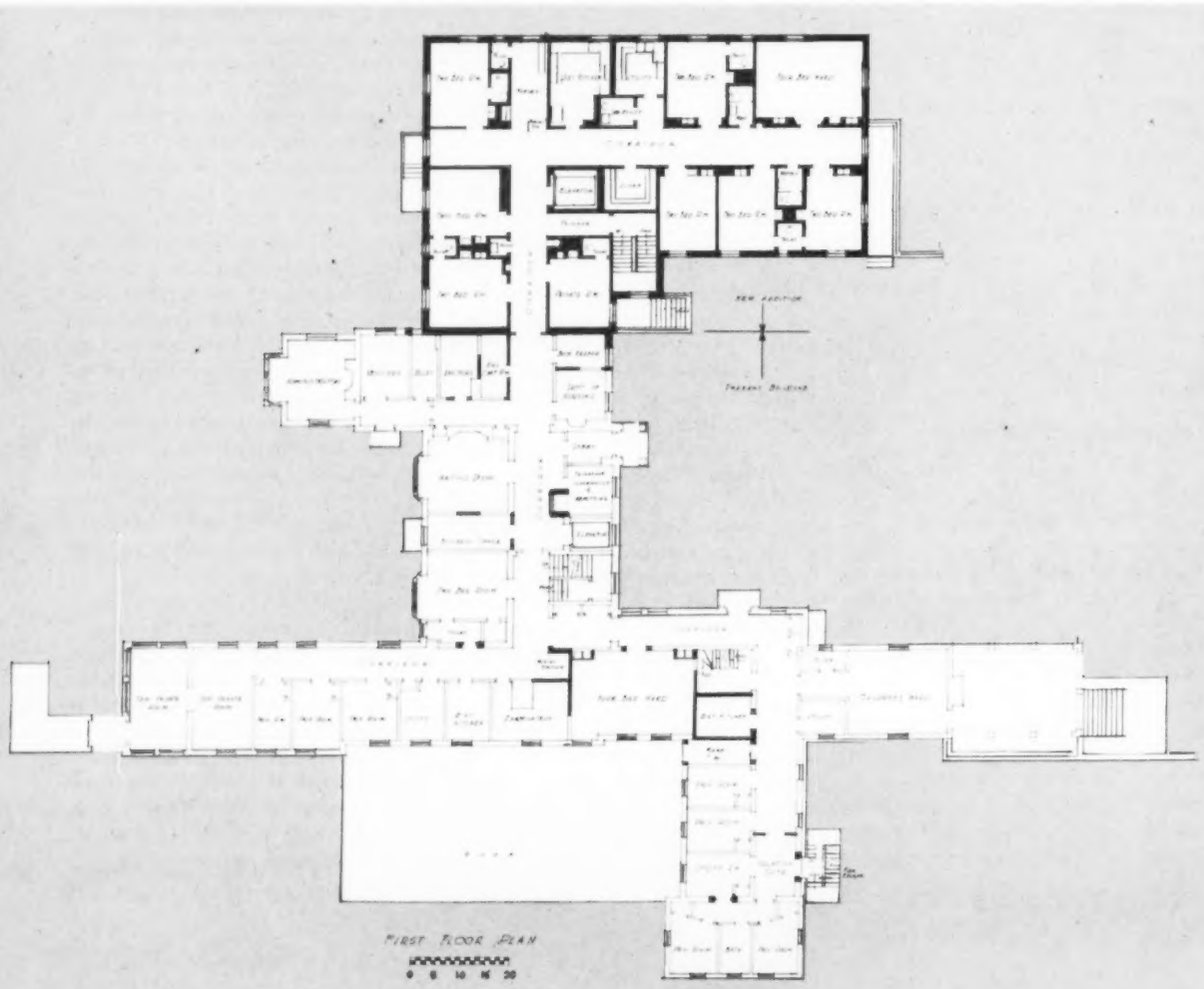
Continuing the series on hospital modernization and expansion

They Put Old Rooms to New Uses

THE original building of the Monadnock Community Hospital in Peterborough, N.H., was erected in 1915 as a private home at a cost of about $65,000. It was solidly constructed of brick and stone, attractive in design and so arranged that it was easily remodeled, enlarged and equipped as a 20 bed hospital in 1923 at a cost of $200,000. At that time many of the nurses and employes lived in the building, but later most of them were moved into a nurses' home in the village and the hospital became a 36 bed unit. It remained so until 1950 when the present facilities were completed.

In planning the expansion program, the hospital's building committee faced these problems: How much should the bed capacity be increased? To what extent should the facilities for ancillary services be modernized and enlarged? How could the services in the old building be efficiently coordinated with those in the new? The committee decided to add to the bed capacity only as many beds as were consistent with the present needs, and to expand and modernize the facilities for ancillary services enough to take care of a further increase in bed demand when and if necessary. Therefore, only 16 beds were added for medical and surgical use and none for the maternity unit.

Plan of the first floor, with the addition and remodeled areas shown in heavy lines. On this floor, the old record office became the director of nurses' office; the men's ward was converted into a children's ward; kitchen and dining room were moved to the basement (not shown) and the space was used for a four-bed ward and an examining room.



ADMINISTRATOR:
Harold S. Fuller
Monadnock Community Hospital
Peterborough, N.H.

ARCHITECT:
Kendall, Taylor & Co.
Boston

For economy and efficiency, it seemed advisable to have all medical and surgical house patients on the first floor of the old and new units and to use the second floor of the old building as the maternity department. So all additional beds are on the first floor of the new north wing.

As the committee had a somewhat limited budget with which to remodel the old building itself, it confined its thinking to changes in the use of the existing rooms rather than to expensive construction changes.

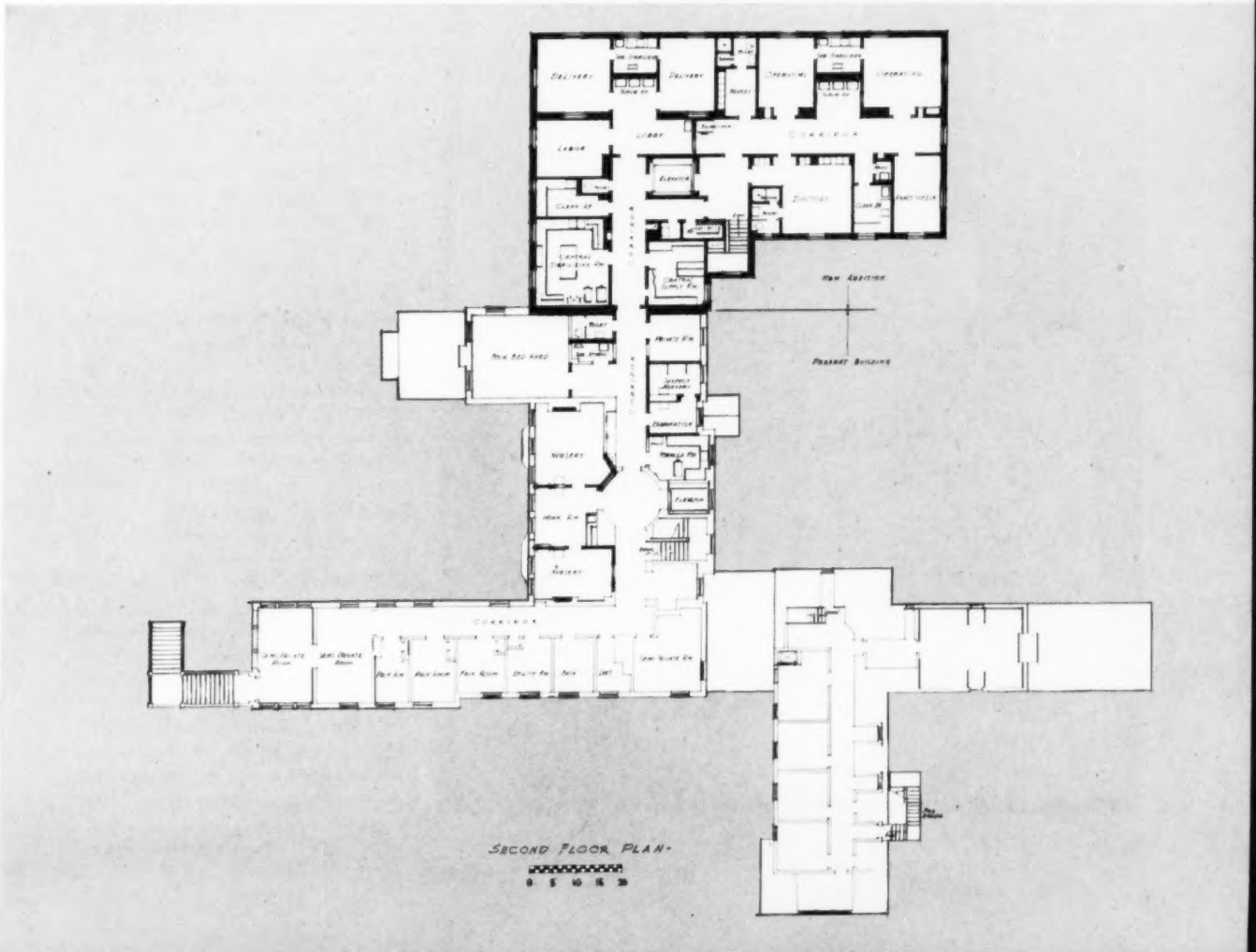
In the basement, the old boiler room became a cafeteria and a storeroom. Part of the laboratory is now a doctors' dining room, and the rest of the room was added to an old storeroom to make ample space for an attractive nurses' dining room. The x-ray restroom became a dishwashing room.

On the first floor, the old record office is now the office of the director of nursing. One-half of the old accident room is now a doctors' coatroom and the other half is part of the main corridor. The men's ward in the east wing is now a nice sunny children's ward having its own screened-in porch. The old kitchen is now a four-bed ward, the walk-in refrigerator is a diet kitchen, and the employes' dining room is an examining room. With the addition of an outside entrance and a new partition, the rooms in the old south wing can now be used as an isolation suite.

The second floor construction changes were somewhat more extensive than those in the other two floors. This is the maternity unit and certain required changes were necessary because of the state health laws. The old operating room makes an excellent four-bed room. Two old bedrooms and a utility room were made into two nurseries between which is a common workroom. The delivery room was made into an adult isolation room and a suspect nursery, and the doctors' room is now the babies' formula room. The old nursery is now a semiprivate room and is also used as a "rooming-in" suite when it is required.

All the changes in the old building were made at a minimum cost, but the coordinating of the old with the new has proved most successful. The total cost of construction and remodeling including architects' fees was approximately $525,000. Equipment and furnishings cost $40,000.

Second floor addition and new construction (shown in heavy lines). Even more extensive remodeling was necessary on this floor because it is the maternity section, and structural changes were needed to comply with state laws. Delivery and labor rooms were moved; their space is now used for a suspect nursery and an isolation room.



To make interpretation of services easier—

Consolidate Professional Reports

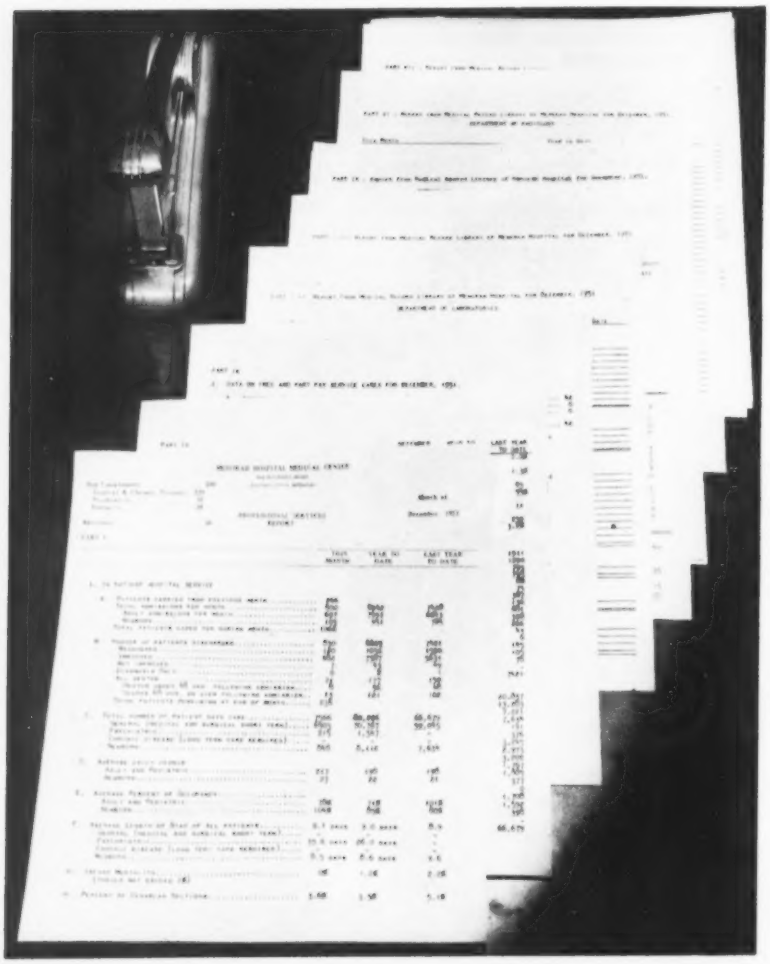
DAVID LITTAUER, M.D.
Executive Director*
Jewish Hospital
St. Louis

GORDON E. SONCRANT
Director*
Hancock County Memorial Hospital
Britt, Iowa

*Dr. Littauer was formerly director of Menorah Hospital Medical Center, and Mr. Soncrant was assistant director for administrative services.

MONTHLY and yearly financial statements with their balance sheets and schedules of special funds, statements of income and expense, and departmental breakdowns are commonplace exhibits of the operations of most of our hospitals. The surface evidences that hospitals are businesses, they are understood by most trustees and are the subject of detailed analysis and debate by executive committees, finance committees, community chests, Blue Cross plans, and other groups and organizations that impinge on the fiscal affairs of institutions caring for the sick.

The monthly professional report is as valuable as the financial report.



The reports of the professional service departments, which perform the primary mission of patient care for which our hospitals exist, are rarely as well prepared, or as widely distributed, or as thoroughly understood. They may be submitted by some departments but not by others. They may lack uniformity from month to month. Often they contain data which serve no useful purpose. All too frequently they are filed in separate departmental folders, relatively inaccessible to anyone but the administrator. They are rarely distributed to responsible members of the governing board and of the medical staff so that they may gain knowledge and perspective of the professional work of the hospital.

Let us consider what monthly reports the administrator should have if he is to keep abreast of the clinical activities of his hospital. He should receive a report from the medical records department, which reflects the activity of patient care within the hospital. In addition he should be provided with service statistics from the clinical laboratories, x-ray department, blood bank, emergency room, operating room, physical therapy, and outpatient clinic. Reports from these departments are usually considered a minimum for the average hospital, but many of our larger institutions have other professional services for which monthly analyses are prepared. They are in addition to the statistical data the administrator and others require concerning fiscal affairs, plant operation and maintenance, personnel and other administrative services.

All of these reports of the work of the professional service departments can be combined advantageously into one comprehensive medical audit. In-

asmuch as the medical records department is the hub of statistical reporting, the consolidated statement can be developed around the customary monthly statement from this department. Medical records employes are trained in the preparation of statistical data relating to the clinical services of the hospital and are generally qualified to recognize medical terms.

When the administrator determines the information he needs he may ask the medical records librarian and department heads to confer and draft sample monthly reports, which should introduce similarity among forms for the reporting departments whenever feasible. Daily work sheets for each department can be set up to tabulate statistics for the monthly report. At the end of the reporting month, the work sheets for each department are sent to the medical records librarian who checks them for accuracy in computing totals, and prepares a duplicator stencil tabulating statistics in the manner and form previously worked out. Normally one sheet should be large enough to contain all statistics submitted by any department, but additional sheets may be added if necessary. After the reports have been stenciled, a gathering process takes place, and all monthly reports for that particular month are consolidated.

The administrator who receives one consolidated report containing the analysis of all types of service to patients can easily interpret professional activity within the hospital. The consolidated medical audit, with cumulative totals, enables him to review statistics for the present month, as compared to year-to-date statistics, and if desired and provided for, last year-to-date statistics.

Wide distribution can be made to interested groups or persons. At Menorah Hospital, copies of the consolidated medical audit are furnished to each member of the executive committee of the medical staff, to chairmen of the clinical departments, to certain administrative department heads, and to the medical care committee of the board of directors. An informed executive committee can analyze the activities of the hospital concerned with patient service and can become a bulwark of strength to the administrator, interpreting the activities to the rest of the staff. The chairmen of the clinical services within the hospital can spot areas of strength and of weakness. Copies are posted on the bulletin boards in the staff lounge, in the medical library, and in the medical records room itself for perusal by all members of the staff, so that they too acquire a perspective of the professional work of the entire hospital. Members of the board of directors who serve on the medical care committee (which deals with the medical program of the hospital) can carry out their duties in more intelligent fashion by receiving statistical data of patient service. They can ask why the consultation of necropsy percentages are lower than normal, or why the rate of cesarian sections is high. Moreover, an informed director who knows that the clinical laboratories perform 75,000 tests per year, and the department of radiology has taken 10,000 x-ray pictures in the previous year is an effective interpreter of the value of his hospital to the community.

The consolidated professional service report can be submitted to inspectors from approving bodies and can be used to accompany requests for approvals for residency and internship training. We have found that visiting surveyors from the American Medical Association, American College of Surgeons, and so on, welcome the perspective and the packaged convenience offered by the professional service report.

The preparation of the professional service report does not require much additional work on the part of the medical records librarian. A great deal has already been performed in each reporting department, where daily work sheets are maintained and totaled. The extra work, amounting to only a few hours per month, comes in checking for accuracy of totals, typing and running off stencils, and gathering the sheets.

We believe that the consolidated professional service report is as valuable to the staff physician, the hospital trustee, the administrator, and interested community groups as is the monthly financial statement because it focuses attention on the activities and procedures which have to do directly with the prime function of hospitals —the care of patients.

ADMINISTRATIVE CAPSULES

HOW ACUTE ARE YOU?: Not all diseases kill "acutely." Many of them take a long time to do it and some do, indeed, take a lifetime, demoralizing families as well as individual sufferers. Is the exclusive "acute" general hospital taking this human tragedy into account as it discontinues its service to certain patients only because of their poverty, the duration of their illness, or a preference for seeing them in beds that are distant from the hospital?

SOMETHING TO THINK ABOUT: You can command the best in medical service provided you can pay for it somehow. Like any other commodity, this service is still available in limited supply in the market places of the world. The personal doctor-patient relationship, which is so much in demand, is purchasable by those who can afford the price. The doctor cannot be expected to make a living from service to the poor. People must therefore be willing (a) to share the burden of such an expense through group insurance or (b) to pay his bill outright, through voluntary or compulsory taxation. Which would you have?

SICK ADULTS fear the impersonal hospital like children fear doctors, and with more justification. No one craves personal attention more than the sick man who clutches at straws in his struggle for survival. Unless the administration of the hospital takes this human phenomenon into account, it will not achieve fulfillment for its aims.

UNDERLYING ALL STIMULI to invention and discovery will be found a strong element of scientific curiosity and a natural desire for an appropriate reward, both of which are universal in qualified men.

THE LONGER WE LIVE the more sure can we be that death will come to us only after a period of prolonged illness. Have our hospitals taken this into account?—E. M. BLUESTONE, M.D.

Take Service Extensions Off the Floor

Continuing the Time and Motion Studies in the Operating Suite

FREDERICK E. MARKUS
Markus & Nocka, Industrial Designers and Engineers, Boston

ONE of the most vexing problems in the planning of operating rooms is the disposition of service extensions: suction and electric power. In one of the earlier illustrations in this series of articles a sketch was reproduced showing a nurse untangling tubing and electric cords from the legs and casters of portable equipment during the clean-up after a fracture case. As bad as the incident looked in the illustration, the actual difficulties defied complete description on paper. Obviously, a floor cluttered with tubing and electric cords is a serious tripping hazard. Furthermore, a sudden tug could conceivably break a kinked cord, inducing a short circuit that might cause an explosion.

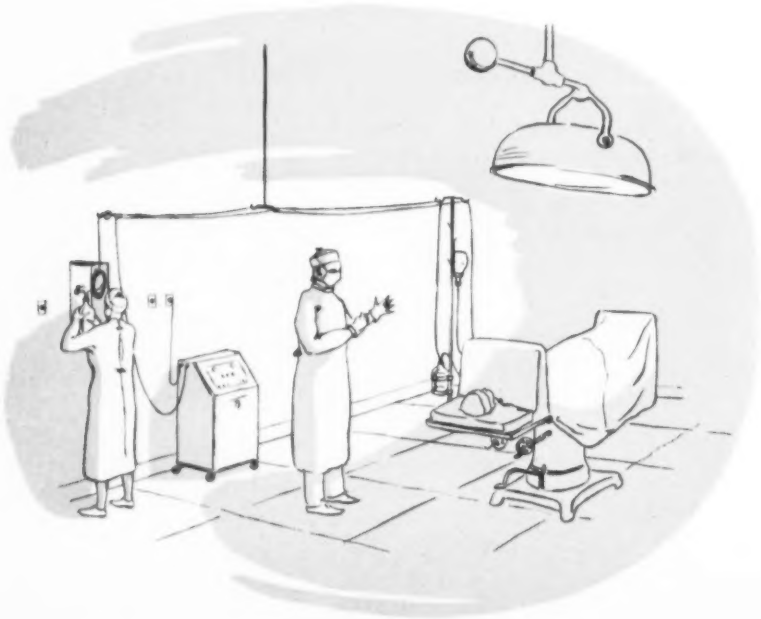
For some reason, the commonest location for suction outlets is on the wall near the floor. Perhaps the only justification for this inconvenient location is that since the tubing conventionally crosses the floor less tubing is required. The same justification might be applied to power outlets if it were not for the fact that each receptacle placed 5 feet above the floor saves many dollars by obviating the need for an explosionproof type.

If this principle of saving tubing and electric cords were carried to its logical conclusion, one would say to place the outlets in the floor under the operating table. However, this has been tried and found wanting. In these cases, the battered service outlets were soon abandoned and the conventional wall outlets were again resorted to.

When the problem is carefully examined in all its aspects, the following solution becomes apparent:

1. There need be but one service point for suction and electric current.
2. All contacts or outlets including suction are at eye level, making gauges easier to read.
3. Place outlets on wall adjacent to the neck of patient on operating table.
4. Go up to approximately 6 feet 10 inches height instead of down and cross to a new type of I. V. pole attached at the usual place on the operating table. This pole would be equipped with hooks at the top for tube and cord support and would provide a clamp for the primary suction bottle at operating table level.
5. Provide intermediate cord and tube supports by means of a ceiling hanger or crane from wall.

An obvious criticism might be that an extremely short nurse would be unable to hook the tubing or cord at this height. However, with two hands either tubing or cord can be looped up into an inverted U to extend the reach by approximately 8 inches. We have yet to find a nurse who cannot reach to 6 feet 2 inches above the floor. This overhead arrangement permits accurate determination of required lengths of cordage and tubing. It does not contaminate the sterile area. It takes the suction bottle off the floor to a much safer place and actually reduces the amount of sterile tubing required. Finally, in an area where accidents should be reduced to a minimum, the foregoing hazards appear to be eliminated.



Suction valve is in a recess at eye height with tube and electric cord suspended overhead to I. V. pole. The tallest surgeon has head clearance and the shortest nurse can hook tubing and cords by making of them an inverted U with two hands. The primary suction bottle clamps to I. V. pole at operating table height. A ceiling-mounted hook supports tubing and cords at half point between wall and operating table. The floor is clear of obstruction for both circulation and mopping.

Top Management Has Its Troubles, Too

A study of the upper branches of the hospital tree

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IT HAS often been said that the price of executive leadership is isolation and separation from the companionship of fellow creatures. In our hospitals it sometimes appears that the administrators, the assistant administrators, and even the department heads have some knowledge of the price they pay to hold positions as executives.

STRUCTURAL RELATIONSHIPS

The purpose of this article is to examine some of the structural relationships that we have established in our hospital organizations and to raise some questions that are probably being raised by many people who now hold responsible jobs in hospitals. In raising these questions, it is not our intention to foist upon the intelligent reader any formula for hospital organization or any unsophisticated comparison between the hospital and other types of human organization. Among the questions that probably need serious study if we are to develop any new perspectives and new approaches in trying to improve our present organization of hospital personnel are these:

Is there a limit to what the hospital administrator can delegate? Just what is the job of the assistant administrator? What factors enter into the establishment of a hospital department and a position as department head? How many separate functions can the administrator coordinate and supervise effectively?

Certainly no formula exists for answering the foregoing questions. Even general approaches will be tailor-made and modified to suit the needs of the individual hospital. However, the questions seem to be of interest to the administrators, the assistant administrators, and the department heads in three nonprofit, short-term, general hospitals recently surveyed by staff members of the New York State School of Industrial and Labor Relations at Cornell with the cooperation of the Central New York Regional Hospital Council, Inc.

The administrators have pointed out that one starting point in analyzing organization structure, delegation from the top position, and personnel relations among the top administrative staff members is to examine the personal background, the interests, the knowledge, the skills and the attitudes of the person who is administrator. The administrators who were interviewed appeared to feel that the factors just mentioned might influence more than any others what is retained and what is delegated at the top level.

For example, the former director of nurses may exhibit the liveliest interest in that department and may visit all of the patients daily; the former purchasing agent may continue to act as purchasing agent, particularly in a small hospital, and the former manager of the business office may demonstrate his greatest personal interest in financial areas, with relatively less emphasis on other aspects of administration.

Several questions arise in regard to the job of the administrator.

1. To what degree should he develop his job to encompass those things that he knows most about and does best?

2. To what degree will such a course result in his operating at the department head level instead of the administrator level?

3. Since so many diverse and specialized functions fall under the general supervision of the administrator, does he really need more specialized staff assistance to help him carry out his responsibilities in budgeting, personnel administration, and so forth?

The whole subject of work planning and organization, delegation, supervision and control by the administrator and the department head seems to hold possibilities for research far more exhaustive than the survey on which this article is based.

HE'S THE BACKUP MAN

Two of the three hospitals surveyed employ assistant administrators. In both cases, the assistant administrator is clearly the designated backup for the No. 1 position, which he assumes in the administrator's absence. When both officials are present, however, the responsibilities of the second position are less easily definable. At the time of the survey, neither of the assistant administrators had been associated with his present hospital long enough for his position to be fully developed in scope, or fully established as assistant administrator in the minds of the department heads. The latter view applied especially to department heads of long service who had enjoyed for many years the privilege of reporting directly to the administrator, and who questioned reporting to a recent recruit.

The rôle of the assistant administrator is one that requires further study before worth-while conclusions can be drawn. Is he to share over-all supervision with the chief executive? Is he to divide supervision with the chief executive, so that each takes a group of departments under his wing, in order to spread full supervision over 15 to 20 departments? Is he to act

as internal administrative officer, over hospital departments, while the administrator handles relations with the medical staff and many other relationships external to the hospital? Is he to be the administrative assistant to the top position, to supervise department heads only in the absence of his superior? Or is this to be regarded only as a training position, temporarily held by an aspirant to a position elsewhere as administrator?

NO SINGLE ANSWER

There need not, and probably should not, be a ready answer to these questions. Not only is it likely that the answer will be developed by each hospital but it may be arrived at only after a period of trial with the individual job incumbent. The period during which the status of the assistant evolves, however, appears to be one of uncertainty, both for himself and the department heads.

Any measures that can be taken to clarify the status, the responsibility and the authority of this position, apparently that of second in command of the hospital, should contribute to improved administration and might also contribute to reducing the exodus of assistant administrators.

Each of the hospitals surveyed maintains from 15 to 20 separate organization units or departments. Some department heads and supervisors report to the administrator; some to the assistant administrator, and some to both—on diverse or on the same matters.

The establishment of this variety of specialized services has not been decided solely by the administrator and the board, but is strongly influenced, and in some measure controlled, by the standards of agencies outside the hospital. These are agencies the approval of which the hospital must have, or may want, in order to carry out its own program.

The nature of modern hospital operation and the advance of medicine and patient care lead to increased specialization, and appear to be leading to increased departmentalization. The increase in number of departments involves, for the administrators with or without an assistant, direct supervision of from 15 to 20 "department heads."

The title, "department head," has been placed in quotes in order to raise this question: What is a department, and what is a department head, and how many such positions can the administrator, or the administrator with his assistant, successfully supervise?

In the hospital, there seems to be an imbalance of organization structure. Department head positions are of extremely unequal weight. Differences in responsibilities, professional status and training, size of organization, supervision required, and personal abilities among department heads all merge to create a situation that prevents administrators from giving equal attention to all departments, and all department heads from having equal access to the administrator.

This so-called "imbalance" seems seriously to affect upward, downward and lateral communication among the supervisors of each unit, all of whom should be working together to carry out the purposes of the hospital. More as a parenthetical note, it seems also to inhibit free discussion at department head meetings called by the administrator.

The administrator of one hospital seemed to feel that 15 or more separate departments had developed owing to the high degree of specialization in the modern hospital, and the department heads appeared to feel that the "span of control," that is, the supervision of 15 or more separate departments by the administrator, worked out satisfactorily. However, from the point of view of department heads, one summed up the feeling of several in approximately these words:

"I believe that too much responsibility is placed on my position. I am most willing and have proved my willingness to assume responsibility, but I believe I am called on to make decisions that should be made in the administrator's office.

"This happens because the administrator has too many departments to supervise. I hesitate to go to his office each time I would like to. After all, mine is only one of many departments. There are other departments that are more important and that need more of the administrator's time."

The foregoing quotation, in its essence, represented the view of several department heads. In some cases, it may point to the organization questions that this report is intended to raise; in others, it may point to the need for development of supervisory personnel. In any event, there is no easy solution to the problem. The creation of separate departments may have been accelerated by specialization. The practice of setting up so many "department head" positions, or so many positions on the same plane of organization, that is, all reporting to top management, may have had behind it the well intended motive to provide non-money, status incentive to deserving supervisors. Whatever the reasons, and whether or not hospitals recognize departmental structure as a high priority problem, it is one that has been cited repeatedly by department heads.

Approaches to a solution, which bear investigation far beyond the limits of this report, may lie in some appropriate combination of the following: (1) more effective utilization of one or more positions at the assistant administrator level; (2) regrouping and consolidation of smaller sections under major departments; (3) regrouping and integration of smaller sections under common supervision, or (4) more adequate development of staff positions to assist the administrator in coordinating functions common to all hospital departments, or in coordinating several groups of specialized activity.

The previous paragraphs have called to attention that organization relationships among administrators, assistant administrators, and department heads are not always clear to the people who hold these positions.

WHERE DEPARTMENT HEADS FIT

Organization analysis cannot be cut off at the top management level. Department heads who were interviewed brought out the importance of maintaining a clear understandable system of working relationships at all levels and across all departments of the hospital.

Among department heads themselves, questions of responsibility and authority seem to be particularly complicated:

1. When responsibility for the supervision of a department is shared by the medical staff and the administrative staff.

2. When responsibility is shared by the administrator and the assistant administrator without clear definition of who reports to whom and on what matters.

3. When organization changes are made.

Where the supervision is shared by medical and administrative staff, a form of dual supervision has been es-

(*Continued on Page* 148)

Create New Health and Welfare Department

Hospital programs not affected under President's F.S.A. reorganization plan; new assistant to have broad powers

UNDER the new Department of Health, Education and Welfare, the federal government's hospital programs would in no way be affected adversely. There is on the other hand the probability that they will benefit from the reorganization, the first to be put into effect by the Eisenhower administration.

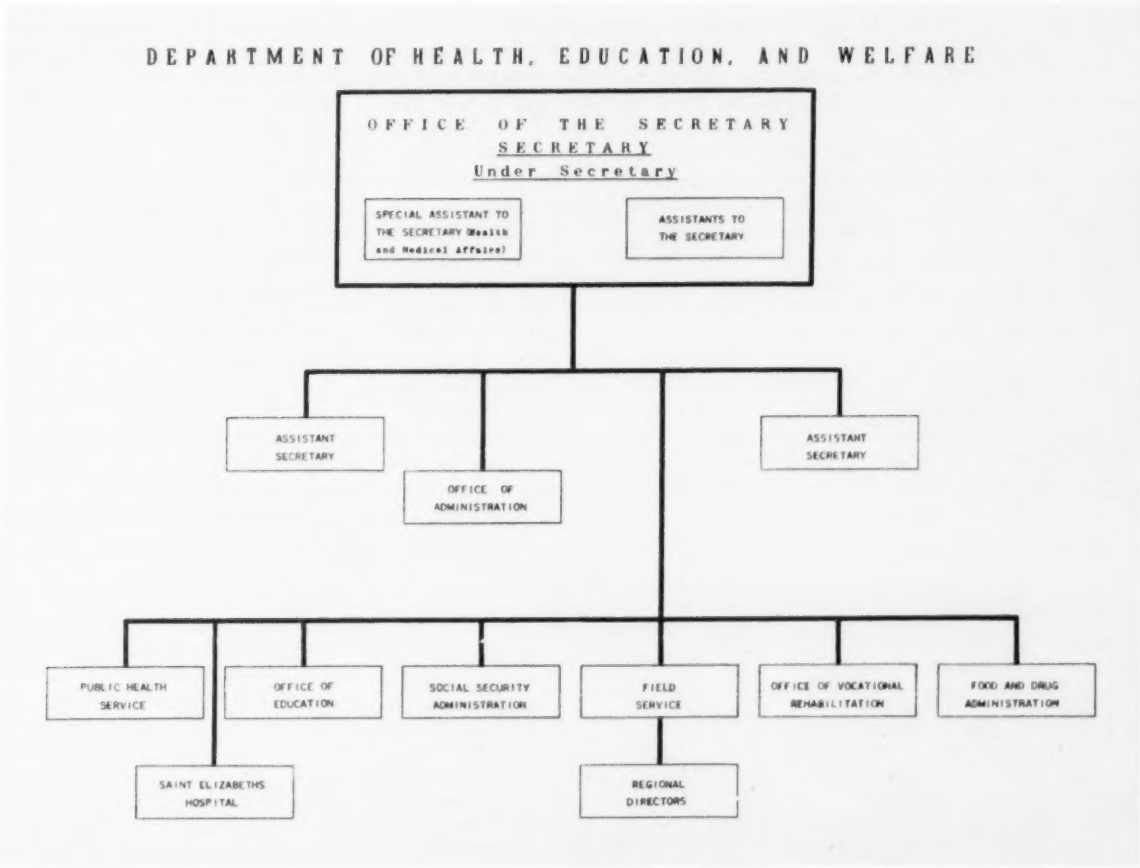
The President repeatedly has said he believes the federal government should stimulate the construction of "much needed" hospitals; under the new department he and Secretary Oveta Culp Hobby will have efficient machinery for control of hospital and other programs, so that they may discourage or encourage as they see fit.

This appraisal is based on a detailed examination of Reorganization Plan No. 1 of 1953, the official document presented to Congress; on a careful study of the job description for the new Special Assistant to the Secretary for Health and Medical Affairs; and on a review of statements, oral and written, by President Eisenhower and Mrs. Hobby, who moves from Federal Security Administrator to secretary of the new department.

The setup of the department is not complicated, and follows the usual pattern for cabinet departments, with the addition at the top level of an official who would carry considerable power in his own right and represent and/or advise the secretary on all health matters, within and outside the department.

As the first step, the present structure of the Federal Security Administration is eliminated down to the level of the components, such as Public Health Service and Food and Drug Administration; these components were created by laws passed by Congress and, with one exception, are

(*Continued on Page* 170)



The First Hospital Health Museum

shows patients how to keep out of the hospital

By BRUNO GEBHARD, M.D., DANIEL E. GAY AND VINCENT G. KLING

SINCE the first hospital came into existence, doctors' and nurses' teaching and training programs have been as much an integral part of the hospital as patients' bedrooms, laboratories and x-ray service. Never before, however, has a hospital entered into a positive teaching program for the general public. It is not enough to teach a person who is ill how to get well; the reverse should be true. He should be educated to avoid being hospitalized. The hospital should be considered the teaching center for lay people of all ages.

The business of health education, of which patient education is a part, is to enlist the participation of an informed public in matters of personal and public health. Patients are the specific public of the hospital; they are sufferers; they want to get well and to stay well; they are open for advice; they are motivated to change behavior and attitude; they want to know what ails them and whether prevention of recurrence is possible. Patient education in hospitals has to be carried on in an organized fashion; the modern hospital cannot leave it to chance action of doctors, nurses or administrators.

Patient education is the doctor's job, and Charles Mayo's old saying holds even today: "It is the physicians' fault when the laity does not understand them."

With all this in mind, the Lankenau Hospital in Philadelphia, when considering a $10,000,000 building program, felt that facilities must be provided to enter into a positive health program for the community, and adopted the health museum as the best medium for capturing public interest in community health.

The concept of a health museum integrated with the hospital facility has given the architect a new and powerful design technic. The location of the health museum adjacent to the main entrance sets the pace and identifies the basic positive health approach of the new Lankenau Hospital.

The main public entrance is flanked with a glass enclosed, well lighted, and carefully appointed exhibit area to house animated displays for visual health education. Thus, the visitor who enters the new Lankenau Hospital will be impressed with a dramatic, colorful and attractive introduction to the high standard of health maintenance to which this hospital has dedicated its personnel in the past, and its hopes for the future.

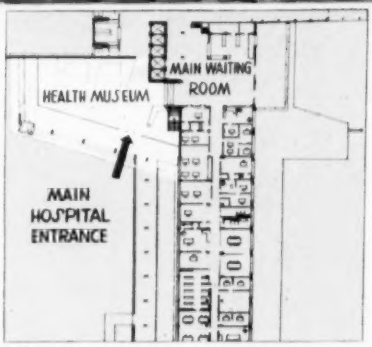
A positive, unemotional, educational activity will be so closely related to the main traffic artery between the front door and hospital facilities that even if the visitor's time is limited, he will be compelled to absorb the impact imparted by the technical animated displays. As further evidence of the integration of health education and hospital, the main lobby which flanks the museum has an inviting open stairway to an auditorium, seating 335 persons, which will be directly below the museum. In addition to lectures and demonstrations, the auditorium will be used for health films for patients, staff and visitors.

The planning of the two facilities has been handled so that the visiting public need not traverse the hospital to enjoy the educational program, the heart of which is at the main concourse of the building. By the same token, patients will not be disturbed by heavy visitor traffic. Another attribute of the physical location of these educational facilities is the easy access for inpatients.

The museum, which comprises 5200 square feet of floor area, is a one-story, free standing unit engaging the main entrance lobby and its protective canopy over the entrance doors. Facing the entrance turnaround is a wall of glass which comprises the north wall of the museum space. The south wall of the 15 foot high museum is a grid of mahogany paneling so designed as to accommodate wall-hung exhibits and flexible lighting. The ceiling, with its acoustical finish and concealed pin point lighting, has been designed to accommodate a diversity of exhibit groups. The west end of the museum is open to the main lobby, receptionist desk, and waiting areas. The use of glass between the outdoor entrance

Dr. Gebhard is director of the Cleveland Health Museum; Mr. Gay, now administrator of Memorial Hospital, Savannah, Ga., was special consultant to Lankenau Hospital, Philadelphia, at the time this article was written; Mr. Kling is an architect with offices in Philadelphia.

Nutrition gets special attention in the museum's exhibits. This one uses the "true or false" technic to teach the facts about vitamins and minerals.



Architect's model and first floor plan of the new Lankenau Hospital and museum. The arrow shows the museum in relation to the entrance.

area and the exhibit space will further dramatize the exhibits even to the casual visitor who will pass the area on his way to the parking facility.

The placement of the exhibits within the large open space will be so arranged as to afford vistas into the exhibit area and to avoid the usual compartmentation found in the average museum.

Museums are recognized as places where one can get unbiased information. Good exhibits appeal to people who will never attend a lecture or listen to a health broadcast. A museum makes people come, stop, look and listen and, last but not least, makes them remember what they have learned when the occasion comes for practical application. Most adults don't want to be talked to, but they like to be shown, and they want to see for themselves. They prefer three-dimensional, animated exhibits with visitor participation, popularly referred to as "push-button" exhibits.*

The real thing—the picture, the film, the exhibit, the model, the demonstration—these are the needed tools for modern patient education, the tools of a health museum.

A museum's business is done along two channels: exhibits and activities. Activities range from guided tours, film showings, class instruction and group discussions to lecture series, radio performances and television.

In some form, at some time, almost every hospital has organized such activities as staff training, open houses with exhibits, and classes for expectant mothers. An educational director responsible to the hospital administration could steer part of these activities into a planned program for patient education. An interdepartmental committee, as policy making body with equal representation by the administrative, the medical and the nursing staffs, would act as a planning committee. Representation of board members and the women's auxiliary is a prerequisite, as it is in all innovations to an established routine. In hospitals having more than 200 beds, the educational director should devote his full time to such a job.

Exhibits at the Lankenau Hospital will be of two kinds. One group will feature normal growth and development of the human organisms, from birth to old age, as all hygiene is nothing else than applied biology. The second group will deal with these diseases where personal living has an influence on the disease, as nutritional disturbances, degenerative and chronic diseases. Whenever possible, animation and visitor-participation items will be used; for example, "Hear-See Your Own Heart Beat." Many Cleveland Health Museum exhibits are being duplicated for the Lankenau Health Museum.

The field of nutrition will get special attention with such exhibits as "Food Facts and Fallacies," "How Many Calories?," "Food Needs Differ With Activities," "Mineral and Vitamin Facts and Fallacies," and "What Made Them Fat?"

The subject of geriatrics is covered under the title, "Live Long and Like It," arranged with such displays as "Your Life Span," "Aging Begins at Birth," "The 4 B's" (baldness, bifocals, bridges and bulges), "As Old As Your Arteries," and "Useful (Youthful) Old Age."

Maternal and child care will feature exhibits like "When Do We Expect Our Baby?" and a large series of birth models from the famous Dickinson-Belskie collection on the human reproduction system.

The new Lankenau Hospital will have 313 beds and 78 bassinets, which means about 10,000 patients per year. As Lankenau is planning a generous visiting hour policy, from 9 a.m. to 9 p.m. daily, one is justified in multiplying this figure by five to estimate the total number of prospective visitors to the museum. At the old Lankenau 26,000 visits were made to the outpatient department. So far as museum attendance is concerned, this figure can be doubled, for great expansion of the outpatient department is planned. The grand total of patients, visitors and clinic clientele comes easily to 100,000 visitors per year. It would be premature to give estimates on the number of school groups, women's organizations, and service clubs which will take advantage of this new health education medium. They might add up to a total of 25,000 persons.

Construction costs of the health museum and the auditorium are budgeted for $300,000, of which one-tenth is allocated for basic exhibits. Mrs. Emma H. Schmidt of Philadelphia was the benefactor of this new venture. An operating budget is tentatively set for $25,000. The returns of any educational enterprise cannot be measured in terms of dollars and cents, but the saving in staff time will be great. Experience has shown that health museums are one of the best vehicles for public relations, that they are also a helpful means in the eternal money raising problem.

* Hospital Management, September 1944.

How to Build a Good Supervisory Staff

The tools are a systematic inventory of the skills and growth-potential of supervisory personnel plus a sensible timetable of promotion and replacement

EDMUND MOTTERSHEAD
Mottershead Associates, Chicago

ALL modern business activity is daily becoming more and more complicated. Complex processes, automatic equipment, new concepts of molecular and atomic analysis of materials, and continuous process plants are all contributing to higher and higher demands made for skill and intelligence on the part of both workers and supervisors in all industries and in all modern institutions.

Add to this picture the complexity of personnel relations, government regulations, and economic fluctuations in a day when the nation must arm for defense and exist on a prosperity level, and many "old time" supervisors are lost indeed.

BETTER METHODS NEEDED

The modern hospital is caught up in the confusing conditions of our times perhaps even more than most businesses and institutions. While costs of everything are constantly spiraling upward, hospitals are being called upon to render services in an ever widening scope and of an ever greater quality—and all this on a far from swiftly increasing budget. In this situation of great confusion, one fact stands clear: Better, more efficient methods of operation in every sphere of hospital activity have to be found, and the supervisory force of the modern hospital must assume a full share of responsibility in finding them.

Hospital management today needs to take a fresh look at its supervisory group. These are the men on the firing line of management, in direct day-to-day contact with specific production and personnel problems, and on their day-to-day decisions rest the numbers at the bottom of the profit and loss sheet.

Supervisors are not merely errand boys for top management, no matter how many of them may think so, and no matter how many of their employers may think so, too. Unless they are capable of growth as executives and are given a chance to grow as executives, the top echelons of hospital management will see a gradual diminution of efficiency and a dim future for the organization.

For 40 years, management men have been preaching that supervisors "must be managers." But what do they mean? Is a manager the fellow who personally checks every aspect of the work, sets up the equipment, "holds the watch" on the employes when they visit the washroom? Or is the manager the man who understands management policy and regulations and acts as an efficient channel of communication between management and employes?

Is the manager the man who has to do everything himself in order to see that it gets done, or is he the man who can delegate both work and responsibility, and equip himself with an adequate follow-up system to make sure that all the jobs get done and on time?

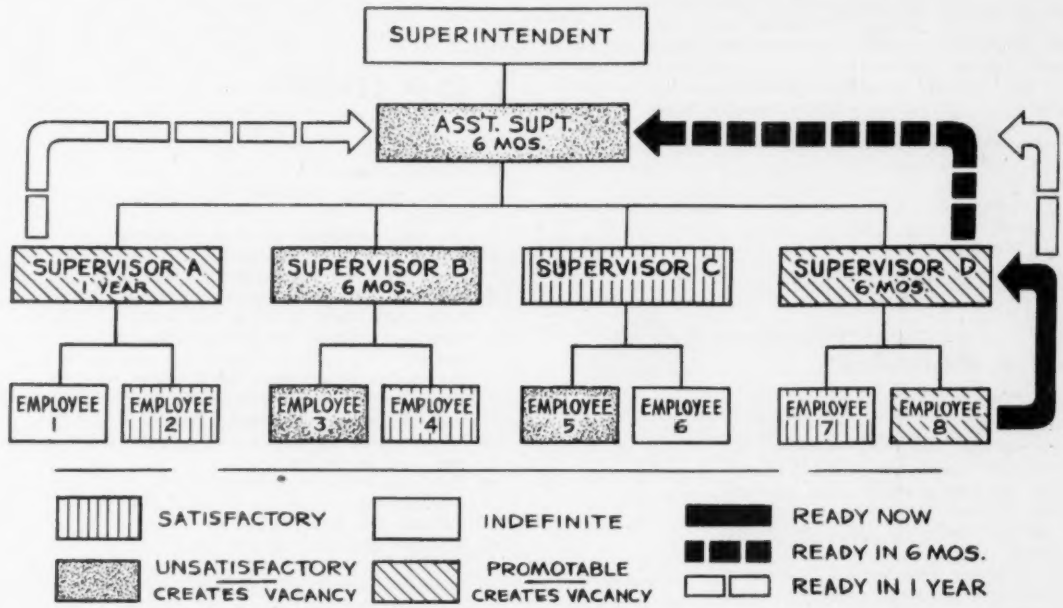
Back in a day when jobs and skills were perhaps simpler, the supervisor who was a "leader"—who could inspire workers to loyalty and a desire to do a full day's work—was often a success in spite of other shortcomings he might have. Today, after years of technological advances, with many tasks deskilled and many workers upgraded far beyond the level of skill of their counterparts of two decades ago, the need for that same kind of leadership is even greater. A war, an uncertain and uneasy peace, rising costs of living, inflation, taxes and a hundred other problems have made people as a whole feel a greater need for personal security, not only financial security, but emotional security as well.

QUALITIES OF A SUPERVISOR

The supervisor who is a real leader, who exhibits fairness, good judgment, a sense of balance, never loses his temper, is not given to snap judgments, who, in a word, lets employes know where they stand at all times, satisfies that craving for emotional security and builds from a sound base a personal loyalty which can go a long way toward making his department efficient.

The old slogan, "If the worker hasn't learned, he hasn't been instructed," is as valid for the modern hospital as it is for any business. Most people are willing to learn, if only during the brief period when their curiosity is aroused by something new. But the efficient supervisor who can instruct quickly, find out what his new employe

PROMOTION SCHEDULE FOR HOSPITAL SUPERVISION



Coded chart of organization shows:

1. Vacancies that will occur because of unsatisfactory conditions and when they will probably occur.
2. Vacancies that will occur because of promotions and when they will occur.
3. Available lower level supervision to fill vacancies and when these men will be ready for promotion.
4. Supervisors with satisfactory performance, but neither considered for promotion nor considered to present a future vacancy.
5. Supervisors whose status or ability is undetermined.

In this instance the assistant superintendent is to be retired for ill health and incapacity six months from date of this schedule. Supervisor "A" and Supervisor "D" are both promotable. "A" will be ready in a year; "D" will be ready in six months.

Employe (8) is promotable and ready to advance immediately to take over job of Supervisor "D" (or possibly Supervisor "A"), and in an additional year would probably be ready to move up another step.

Supervisor "B" must be replaced in six months. Employes (3) and (5) should be replaced immediately. It is apparent that lower level supervision is weak in this organization, and that two of the supervisors have made little attempt to develop effective understudies.

Training requirements to upgrade existing supervision include: Special coaching of employes (2), (4) and (7); coaching of Supervisor "C" in developing understudies; intensive training of six new employes and understudies now hired.

already knows, explain and demonstrate the work, and put the man on his own with a feeling of confidence will help achieve substantial savings in operational costs through reduced training time, reduced waste efforts, and reduced retraining needed.

The most willing worker in the world is baffled when he gets inadequate or incomplete instructions. Job assignments, information about equipment, new forms to be filled out, new work regulations, safety practices, and a host of other matters are subjects in which the modern supervisor must be effective in instructing his people (to say nothing of his ability to explain hospital policy and the "economic facts of life").

In spite of the school of thought which claims we have yet tapped but a small portion of the human potential, the great advances in hospital operations during the next few years must come from technological improvements, particularly from the many minor changes in method and machine attachment which can be dreamed up and engineered on the spot by one worker or two, or a worker and supervisor.

The supervisor who is familiar with the basic thinking of work simplification and job methods improvement, who is alert for opportunities in his own department to put that thinking to good use, and who can keep his men sold on the advantages *to them* of doing things better and more efficiently will in the long run develop faster as top executive material.

The four aspects of supervision mentioned—skill as a manager, as a leader, as an instructor, and as practical engineer—add up to the individual supervisor's growth potential, his capacity to develop personally into higher level executive personnel.

The man who can accept criticism, who can correlate his daily activities with the other activities in the hospital, who can make decisions for himself, and who has a personal timetable for advancement, will be the man with the kind of growth potential top management wants and needs.

The continuing problem of supervisor upgrading and executive replacement is one which plays hob with many institutions. The fact that "Old So-And-So" is about to retire because of ill health and must be replaced, and the fact that "Young Such-And-Such" hasn't got it and also must be replaced is recognized both at the top and down the line, but nobody does much about it until some real problem arises. Then, as usual, a decision is made, too fast, under pressure, and frequently wrong.

RATE YOURSELF

Supervisors need more highly developed skills to cope with the problems which come with modern technology and new methods of hospital organization.

These skills include those of manager, instructor, leader and engineer. Of key importance from top management's standpoint is the individual supervisor's "growth potential" to make plans for future upgrading to higher executive levels.

Score yourself 3 points for each YES.
Deduct 3 points for each NO.
A rating of
120—is excellent;
90—is good;
60—just about gets by.

1. AS A MANAGER?

	Yes	No
1. Do you know and obey yourself all the necessary hospital rules and regulations?		
2. Are you adequately informed as to all departmental cost factors so you can make a systematic effort to reduce costs?		
3. Have you a departmental "manpower inventory" so that you operate efficient manpower control?		
4. Is your personal conduct such as will command respect from both subordinates and supervisors at all times?		
5. Do you make careful investigation and get all the facts in a situation before reaching any decision?		
6. Are you constantly alert for the health, safety and well-being of your workers?		
7. Are you consistently up to date on all necessary paper work, reports?		
8. Do you act as an efficient channel of communication between workers and management, representing management to workers accurately?		
9. Do you operate your department and your own job on the basis of adequate planning and scheduling so that you avoid a perpetual "state of emergency"?		
10. Do you have and USE consistently a good follow-up system, based on date pad or similar device?		

2. AS A LEADER?

	Yes	No
1. Are you consistently fair — do you avoid showing partiality or holding grudges?		
2. Do you consistently give full credit where it is due, especially to men under you for good ideas?		
3. Are you thoroughly acquainted with each man under you so you know something of his problems, hopes, fears?		
4. Do you try to anticipate the problems and possible gripes of your men in order to avoid difficulties?		
5. Do you back up your employes when they are in trouble?		
6. Can you listen sympathetically to a worker when he has a problem and conceal your own possible irritation?		
7. Do your men feel that you are willing to pitch in and work or help yourself when necessary?		
8. Do you spread the "dirty work" around evenly?		
9. Are you thoroughly aware of the capabilities and weaknesses of each of your men so you can put the right man on the right job?		
10. Are you dependable and predictable? Do your men know where they stand with you at all times?		

3. AS AN INSTRUCTOR?

	Yes	No
1. Are you alert and willing to help both new and old workers when they need it?		

The answer to much of this trouble is executive manpower control at the top—a systematic inventorying of the management skills and growth potential of supervisory-executive personnel, coupled with a timetable of promotion and replacement which gives top management a definite command of the situation. In this fashion, decisions are made months before action must be taken, and time is allowed to take all necessary steps to make replacements and promotions effective with the minimum of disturbance to the hospital's functioning.

A detailed organization chart that includes the entire personnel force should be developed. Then the men and women who are performing the various executive and supervisory tasks should be judged and an inventory taken of just what the organization has. Who is "on the ball," who is ready for promotion, who needs replacement, who is doing acceptable work but appears unsuitable for promotion, and, above all, when will these changes have to take place.

In making such inventory-analysis, there are three things that can be done to make your efforts more productive of useful facts:

1. Rate your supervisors. Rate them two ways, with a "form sheet" or performance rating or merit rating sheet, and also rate them on the basis of actual work records, reports of complaints, mechanical failures, grievance reports, absentee records, turnover records, and other data compiled on each department in the normal course of operations.

2. Survey their background. Use both questionnaires and personal interviews (planned) to inquire into the supervisors' backgrounds, their family status, education, hobbies, interests and habits. The more you really know about these men and women the better able you are to judge how they will act under a given set of conditions and how they will respond to difficulty.

3. Check their judgment. A number of institutions have devised problem-solving tests for their supervisors in which the supervisor or would-be-supervisor selects the best and worst answers from a group of possible answers to a problem question. Poor supervisors with years of experience

2. Do you give a man a chance to make good after being instructed instead of giving "too close" supervision?
3. Do you have a training timetable on each job — how much skill the worker should have and when?
4. Do you have the correct method established before training a worker?
5. Do you make sure everything is ready when you train a worker — all equipment and materials at hand?
6. Do you make sure the work place is properly arranged before instructing the worker — as he will keep it?
7. Do you "qualify" the worker by finding out what he already knows about a job when you begin to instruct?
8. Can you express yourself clearly and effectively when explaining how to do a job?
9. Do you prove the learner either understands or not by proper questioning with HOW, WHY, WHEN questions?
10. Do you follow up instruction with more coaching and encouragement with periodic check-backs to watch progress?

4. AS AN ENGINEER?

	Yes	No
1. Are you constantly alert for short cuts in methods and operations that will help your men and the hospital?		
2. Do you have a methods breakdown on every job in your department?		
3. Have you been trained in and have you used the 4 step method of J.M.T. (Job Methods Training) to improve methods on jobs in your department?		
4. Do you understand the principles of time and motion study?		
5. Are you familiar with the basic principles of work factor analysis, M.T.M. (Motion Time Measurement), and work simplification?		
6. Are you usually successful in selling a new method to "the boss"?		
7. Are you usually successful in selling a new method to the employes in your department?		
8. Are you thoroughly familiar with present materials, machines used in your department, capacities, proper operating procedures, on present job methods?		
9. Do you make provisions to keep "score" on new methods to prove the results, both in efficiency and in costs?		
10. Can you explain to your workers convincingly that methods, improvements and technological advances mean full employment and higher wages rather than "technological unemployment"?		

5. ON GROWTH-POTENTIAL

	Yes	No
1. Is your heart in your job? Is this the kind of work you not only feel cut out for but prefer to do?		
2. Do you habitually make decisions for yourself instead of running to the boss to clear everything?		
3. Can you correlate your activities and day-to-day decisions with the work and problems of other departments?		
4. Are you currently studying ANYTHING of technical or practical business nature to prepare for advancement?		
5. Can you accept criticism as well as help from both subordinates and superiors — gracefully?		
6. Do you cooperate willingly with all other departments including maintenance men and personnel department?		
7. Are you of "even disposition"—calm, not likely to fly off the handle, cheerful most of the time?		
8. Can you think a problem through and reach a sound decision without jumping to conclusions?		
9. Are you willing to admit mistakes and take responsibility for your own?		
10. Do you have a personal "timetable" for advancement so you know when you will be ready for advancement to the next higher job?		

do poorly on such tests; good potential supervisors with no experience do well on such tests, as do good supervisors. These devices are simply an aid for management in an attempt to check the judgment of supervisors, a process which also goes on all the time through day-to-day observations of their habits and decision-making abilities.

In a day when supervisor training is in the hands of the "empire builders" in personnel departments and guided by highly paid management consultants, it may come as a shock to some to have it recommended that supervisors be trained and instructed individually.

The fact remains that "if the worker hasn't learned, the supervisor hasn't taught;" and if the supervisor hasn't learned, he hasn't been instructed by management. Conferences, safety meetings, and a host of other group teaching devices have operated for years on a helter-skelter basis to improve supervisory performance. But the most valuable portion of any of these training programs has been that small time in which each supervisor has a chance to *do* something himself while learning. The supervisor, while instructing the hypothetical new worker on the job and making necessary observations, learns more himself this way than he does from any other "teaching" method. Many institutions are "meeting happy"—everything happens in conferences, meetings and round table discussions.

The man who properly has the responsibility for training a supervisor is his immediate superior, just as a supervisor is largely responsible for the job knowledge and skill of his workers. Ninety per cent of the effective supervisor training that is done is done on an individual and personal basis by the supervisor's immediate boss, and supervisors who fail to improve generally do so because of poor instruction and inadequate performance by that superior officer.

Train supervisors as executives, develop their growth potential by getting them to be better managers, better instructors, more effective leaders and engineers—and do it on an individual basis after proper executive manpower inventory and planning. The results will more than repay your efforts.

Workshop on Hospital Costs

works well in promoting community understanding

EVA H. ERICKSON
Administrator, Galesburg Cottage Hospital, Galesburg, Ill.

HOW can a hospital create broader and more extensive knowledge of the factors which are responsible for hospital costs? How can it get this information to a large segment of the community? What can be done to create in a community the willingness to seek and to listen to the hospital's side of the cost story?

One answer is to tell the women of the town and to charge them with the responsibility of telling others. What group of women would be more willing and ready to listen than a hospital's auxiliary group?

THEY INTENDED TO WORK

The Galesburg Cottage Hospital Service Guild is an auxiliary organization in only its second year of growth. Mindful of its constitutional objective—to create broader and better community-wide understanding of the hospital's problems and needs—it conducted a one-day workshop on hospital costs. The guild decided the meeting should be called a "workshop" because those who attended would work to obtain an understanding and knowledge of Cottage Hospital's costs and then work to spread this knowledge in their day-to-day activities with other people.

Once a suitable date was found and general arrangements were agreed upon, the next big task was to get full attendance at the meeting. The local newspaper carried several informative articles about it. The *Guild-crier,* the organization's monthly newsletter, devoted a full issue to the explanation of the workshop—what it was, what it would cover, and why guild members should attend. In a town like Galesburg, Ill., where many varied organizations abound and where their custom is to call members by telephone, it became necessary to assign the names of more than 300 members to a calling list. This was important, too, in order to obtain reservations for the luncheon, which was to be served in the hospital's dining room.

The meeting itself was held in the nurses' home lounge, which had been set up to accommodate 60 persons. Mrs. J. C. VanAntwerp, guild president, opened the meeting and explained its purpose and the important rôle those present would play in the program. When the curtain went down on the workshop, the curtain would go up for their performance—spreading the information and knowledge they gained from the day's sessions.

Everett W. Jones, vice president of The Modern Hospital Publishing Company, had been invited to present the factors which influence the cost of hospital care. He outlined the difference between the administrative costs of a hotel and those of a hospital, particularly in reference to credits and collections. Many of the women had not realized that a hotel has perhaps a week's accounts on its books, while a hospital is likely to have several months' accounts on its books.

The large inventories of supplies, amounting to some 1200 items, which a hospital must have ready for its patients at all times are not matched by a hotel's inventories, it was explained. Other problems which hospital administration faces and which are nonexistent in hotel administration were reviewed and discussed.

The "workshoppers" clearly saw the problems of having patients to whom all meals are provided by room service, instead of having guests who go to a dining room for meals. The cost of additional dietary services, such as providing special diets, special foods and the actual weighing of some diets, was clearly understood.

WHY LINEN LIFE IS SHORT

Although both hospitals and hotels launder linens, more skilled attention is needed in a hospital. Linen replacement is a greater problem to a hospital, too, since the hospital's occupants use it 24 hours a day as compared to the hotel use of about eight hours a day. The housewives present were quick to see why hospital linen's life span is about one-third that of a hotel.

Both hotels and hospitals have a house and property account. In a hospital, however, all maintenance, cleaning and repairing must be done around a person in bed. In a hotel, this is done in unoccupied rooms. Efficient hospital maids are important in the recovery of the patient, for they must please the patient by maintaining the cleanliness of his room and do their work in a manner which will not disturb or irritate the occupant.

Miss Erickson presides at the workshop which was attended by 60 members of the auxiliary.

It was emphasized that all these additional responsibilities in the varied functions meant more people working, and more employes mean larger pay rolls. Praising our local hotel, which has 0.7 employes per guest, the speaker called attention to the fact that Cottage Hospital, however, has almost two employes per patient per day. The nursing department pay roll per patient per day is greater in a hospital than is the entire pay roll per guest per day in a hotel, he emphasized.

WORKED IN GROUPS

Following this initial talk, the workshop members were divided into small "buzz" groups of six persons. These groups were asked to discuss what they had heard and to decide on two or three questions they wanted to ask. It was interesting to listen to the comments in these groups. Two groups said, "We ask questions, but then we go right ahead and answer them." In this remark lay proof of the workshop's success—the hospital's problems had been explained to an attentive group which left understanding and sympathizing with the hospital's problems instead of questioning their existence.

"How can we get this information to the public?" was the problem of the majority. It was emphasized that each individual had a job to do, not only in her own contacts, but also in creating for the hospital's representatives opportunities to appear before various groups and organizations to explain these facts. It was difficult to convince the group that this process of education is an endless one which must be furthered today, tomorrow and in the months and years which lie ahead. There is no pat answer or method which can be applied.

After luncheon at the hospital, which some of the guild members helped serve, the administrator explained the financial structure of the hospital, what its costs were, what had happened to several substantial bequests recently received, why Cottage Hospital wasn't in the Community Chest, why costs at Cottage were higher than those in the other local hospital, and the effect of conducting a school of nursing on hospital costs.

A lively discussion was started by several former school teachers about the cost of nursing education and the need to have financial assistance for it as for other forms of education.

The workshop ended with a discussion of what an auxiliary organization can do for a hospital. Particularly the group was urged to be missionaries in dispelling misconceptions about the hospital. Misunderstandings cause irritations, irritations hinder recovery of a sick person, and thorough understanding often eliminates and certainly lessens irritations.

It is for the benefit of those who might need the hospital's services that misconceptions should be dispelled. Any actual reports of inadequacies should be reported to the hospital administrator for investigation.

The second way an auxiliary can help the hospital is to provide for the replacement of obsolete equipment and the introduction of the use of new items. Most hospitals, in an effort to keep the charges to the patient at a minimum, do not make any charge for depreciation. Consequently, they have no funds for equipment replacement. If contributions are not forthcoming from auxiliaries and other friends, the hospital has only one recourse to obtain funds for improvements and that is to charge the patient more.

An auxiliary might also be the spark, the moving spirit, in getting a long-term program started which would help to meet all the health needs of the community, particularly as they relate to the hospital.

THEY LEARNED A LOT

By 3:15, the 60 members of the service guild who had been present at the all-day workshop began to show evidence of having reached a saturation point in absorbing the new knowledge. They had been very attentive, eagerly following the speakers and taking notes. Their questions showed real thought and a good grasp of the problems. They were grateful for the opportunity to learn the facts, feeling certain that every aspect of the problem had been openly presented. They realized there was a real reason for hospital costs being at their present level. Many had already decided what they would explain to some particular person of their acquaintance who had been consistently hard on Cottage Hospital.

The workshop served its purpose. Its members had been capably instructed, heard the facts, were convinced. They were ready to do their share to create broader and better community-wide understanding of the hospital's problems and needs.

The Aftermath of a Fire Was

An Improved Safety Program

JOSEPH K. LANE
Personnel Director
St. Paul's Hospital
Dallas, Tex.

A FEW days after the "big fire" at St. Paul's Hospital, Dallas, in October 1951, Sister Alberta, the administrator, had a visit from the Dallas fire marshal. During the course of that call the marshal advised that all personnel be warned against developing a fire-neurosis, and suggested that the ground of fire-consciousness be allowed to remain fallow for a time until the usual "jitters" following such a fire should taper off to a normal attitude toward the fire safety program. This advice was taken and, in retrospect, was the only wise and practical course left open to the administration for it was nothing more than an extension of the important "Be Calm" advice contained in the Standard Operating Procedure which is issued to every department.

PLANNED SAFETY COURSE

At about the same time an official from the education department of the fire marshal's office met with the hospital safety officer to map out a fire school sponsored by the fire department that had been used on a small scale in the past in the hospital. The proposed course was planned for an indefinite time in the future when, it was felt, the need for rejuvenating an active, but not "neurotic," fire-consciousness in the staff would be most opportune and appropriate. This indefinite future date for the school course on fire safety was to be at least six months in the future. All our energies for six months and more would be taken up primarily with maintaining the best care for our patients (limited to the annex building) while the main building (where fire occurred) was remodeled and the new Dallas building was completed and we could move patients into it. The dedication of the Dallas building took place at the end of April, and the fire damage was repaired at about the same time.

In the hospital's safety office, however, the elaboration of the fire safety program, in general, and the completion of Standard Operating Procedures, in particular, went on. Things we had learned from the actual fire had to be incorporated into old and new safety procedure; some nonnursing departments had not received their S.O.P.'s; almost all procedures had to be framed and put in the correct location, and every aspect of a fire safety program had to be considered and worked on. In one sense, that job is almost endless, and, of course, administrative responsibility, supervision and operation are endless.

Besides further consolidating the immediate safety-to-life program, the administration took further steps to remove certain basic fire hazards in the physical structure. Although the fire in October 1951 did, of course, spur on reconstruction of the physical fabric considered to be unsafe at that time, the next step in the removal of fire hazards of major importance was not a direct result of the fire. The major hazard in question was the gabled roof and storage section on the annex building. Removal of this floor and replacement by a modern fire-resistive section was, before the fire, to be the final step of the fire-hazard-area removal program begun in 1948.

The major projects of this program had been the removal or enclosing of four open stairwells in the older sections of the hospital. That much had been accomplished before the fire. On Jan. 13, 1953, the first patients were moved into the new sixth annex section. With the enclosure of the central annex staircase in December 1952, the fire-hazard-area removal program came to an end.

In June 1952, the fire marshal and the hospital finally agreed on dates for holding the fire school, October 20 to 24. The final date, the 24th, coincided with the anniversary date of the fire.

KEY PERSONS ATTENDED

Two weeks before the school was to begin all employes were advised through St. Paul's *Newsletter* that a fire school run by the Dallas Fire Department would be held on these dates from 2 to 3 p.m., and that although it would be impossible for all personnel to attend, at least certain key persons, each to be informed in the course of the next two weeks, would be expected to attend. The next step was for the safety officer, in the name of the administrator, to write a letter to each individual supervisor and department head asking that this nurse, that technician, this maintenance man, and so on be sent to the school regularly. All x-ray and laboratory students and student nurses not on affiliation were to attend. The next *Newsletter*, which came out the day before the school began, issued a general invitation to all personnel interested in attending. This general invitation was accepted by several employes not considered key personnel, which was gratifying to the administration.

When the time actually came to decide on the topics to be dealt with in the course, we chose four subjects out of a list of 15 or so. The subjects chosen were those most safety officers would elect as being most to the point in a short general course. Following is the schedule of subjects.

FIRE SCHOOL
LECTURES AND DEMONSTRATIONS

By Dallas Fire Department
Oct. 20-24, 2-3 p.m. daily in School Auditorium

Mon., October 20: "Chemistry of Fire and Fire Safety."
Tues., October 21: "Common Fire Hazards" and a 20 minute movie.
Wed., October 22: "Evacuation and Fire Emergency" and a new 25 minute movie: "Fire and Your Hospital."
Thurs., October 23: "Use of Fire Extinguishers." Demonstration of different types of extinguishers.
Fri., October 24: Review and Test.
Those who take the course and pass the test will receive a certificate.

Two instructors from the Dallas fire department lecture on fire safety.

"Chemistry of Fire" was chosen as basic, of course. To prevent fire and to fight it employes must know the physical and chemical causes, and how fire works once it gets started. They must know that three things must be present: heat, air or oxygen, and fuel in vapor form. From this basis a discussion was held on vapors and flammable liquids, explosions and mixtures that will and will not cause them, various types of fuel, how paper burns and when it does not (same for wood), how fire travels, where gases go, the theory of extinguishment, and so on. All the hour was punctuated by explosions, and sometimes by non-explosions, all of which made the subject of fire chemistry very realistic. The inspectors from the marshal's office came fully equipped as the "Compleat Arsonist," and the interest of the large audience did not flag.

"Common Fire Hazards" developed some of the subjects touched on the first day, *i.e.* how fire travels, fuel sources, and so on, and then went into detail about various hazardous pieces of mechanical equipment. The major emphasis of this day's program was on good housekeeping and maintenance. The common match came in for a great deal of abuse. The inspectors wisely discussed fire hazards from the point of view not only of hospital safety but also of home safety. And it should be emphasized here that in working up interest in such a school, the *personal* benefit to the employe and his family at home should be pointed out.

This personal outlook was again stressed in the 20 minute movie which followed the informal lecture: "Stop Fire—Save Jobs," a general fire prevention, fire safety film built around fires in factories and why it is important to the employe personally to be fire conscious at all times on duty. It was pointed out that St. Paul's Hospital had had to lay off more than 60 employes for a few months as a result of the fire.

"Evacuation and Fire Emergency" was dealt with first of all from the fire department's point of view. Subjects included the responsibility and authority of the fire chief and the extreme importance of telling the fire department where the fire is when turning in an alarm, instead of behaving like the panicky woman who telephoned the department, screamed "Fire" and then hung up! The inspectors informed the class that no one would pass the quiz who did not memorize the telephone number of the fire department, RI-6543. The safety officer then went over the Standard Operating Procedures for nursing divisions in as much detail as time allowed, showing as often as possible the *reasons* for the different aspects of the S.O.P. Then followed the new movie, "Fire and Your Hospital." This film need not be discussed except to say that it is excellent, it should be shown to the staff of every American hospital at least once a year, and it is a graphic summary of all things a hospital's fire safety program should comprise.

"Use of Fire Extinguishers" brought us out into the open air in the yard next to the nurses' auditorium. This day's activity, a very usual one in fire-fighting training in schools of nursing, dealt specifically with each type of extinguisher in use at St. Paul's. Everyone had a chance to extinguish a fire built in a metal tank, using the correct extinguisher for the class of fire involved. A good time was had by all, especially when two inspectors had a little difficulty in getting one particular fire out. Of course, we amateurs had no trouble at all!

Attendance was excellent and above expectation at all times. It fell down to 95 for the review and quiz. A few divisions and departments failed to be represented once or twice during the five days. Reaction of those who attended the course seemed to be one of enjoyment and appreciation. Although employes have not "gone overboard" they appear to the administrator and director of nurses to be very much aware of their responsibility for alertness. This has been particularly noticeable in their zeal to keep the vertical shafts enclosed by shutting the fire doors on stairwells. To those who passed the quiz (most of the employes) a fine gilded certificate was issued. The safety office was literally pestered the last week of October by those who wanted to know if they had passed and if their certificates were ready!

The Dallas Fire Department did as fine a job of teaching as it did fighting the fire on the night of Oct. 24, 1951.

About People

Administrators


E. E. Glover

E. E. Glover, administrator of Samaritan Hospital, Troy, N.Y., for the last five years, has assumed his new duties as administrator of Ideal Hospital of Endicott, N.Y. Mr. Glover is a member of the American College of Hospital Administrators and a personal member of the American Hospital Association

B. Lee Mootz has resigned as administrative assistant to **Robert W. Bachmeyer** at Aultman Hospital, Canton, Ohio, to become assistant director at St. Luke's Hospital, Cleveland.

James A. Brown, formerly business manager of Greenville General Hospital, Greenville, S.C., has been named assistant director of the hospital. **Fred F. Ellison,** the new controller at Greenville, was formerly assistant superintendent of the hospital. Mr. Ellison also formerly served as administrator of the Hutchins Memorial Hospital, Buford, Ga. Another appointment at Greenville General Hospital was that of **Robert E. Toomey** as assistant director. Mr. Toomey, a graduate of the Columbia University course in hospital administration, was formerly director of the North Country Hospitals at Gouverneur, N.Y.


Charles G. Marion

Charles G. Marion has been named associate director of the Jewish Hospital of Brooklyn, N.Y. For the last two and one-half years he has been serving as assistant director of the hospital. Mr. Marion, who was employed by the Veterans Administration prior to World War II, served as an administrative officer for four years in the army. He also has served as assistant superintendent of South Nassau Communities Hospital, Rockville Center, N.Y., and as director of Terrace Heights Hospital, Hollis, N.Y. He is a member of the American Hospital Association and a nominee of the American College of Hospital Administrators.


Harold Warren

Harold Warren, formerly administrator of Hopkins County Memorial Hospital, Sulphur Springs, Tex., was recently appointed administrator of Central Baptist Hospital, which is now under construction at Lexington, Ky. The hospital will be operated by the Hospital Commission of Kentucky Baptists. Previously, Mr. Warren has been associated with the North Louisiana Sanitarium, Shreveport; the Hillcrest Memorial Hospital, Waco, Tex., and the Stephenville Hospital and Clinic, Stephenville, Tex. He also has been regional director and hospital relations representative of the Texas Blue Cross plan.

Brig. Gen. James O. Gillespie has assumed the command of Letterman General Hospital, San Francisco, succeeding **Maj. Gen. Leonard D. Heaton,** who will head the Walter Reed Army Medical Center at Washington, D.C.

Bernard F. Carr has resigned as assistant administrator of Indiana University Medical Center to become superintendent of Altoona Hospital, Altoona, Pa. Mr. Carr, who has degrees from the Rockland State Hospital School of Nursing, New York University, and the University of Chicago, went to the I.U. Medical Center in 1950 for a residency in hospital administration. He later served as an administrative assistant. A nominee of the American College of Hospital Administrators, he served last year as chairman of the Indiana Hospital Association's council on construction and plant operation.

J. Grayson Brothers is the newly appointed administrator of Grace Hos-

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D. G. Anderson, M.D.

Dr. Donald G. Anderson, secretary of the Council on Medical Education and Hospitals of the American Medical Association, has been appointed dean of the University of Rochester School of Medicine and Dentistry, effective at the opening of the 1953-54 academic year this fall. Dr. Anderson will succeed **Dr. George Hoyt Whipple,** Nobel prize winner in medicine, and medical educator and researcher, whose resignation as dean of the University of Rochester medical school will take effect June 30. Dr. Whipple, who has headed the school since its founding in 1920, will continue to serve on the faculty as professor of pathology. Dr. Anderson, who received his M.D. degree at Columbia University College of Physicians and Surgeons in 1939, has had hospital and academic appointments at Boston City Hospital, Boston, St. Luke's and Presbyterian hospitals, New York City, and at Evans Memorial and Massachusetts Memorial hospitals, Boston; medical school appointments in medicine and pathology at Columbia University College of Physicians and Surgeons, and at Boston University's school of medicine, where he was on the medical faculty from 1942-47, the last two years as dean and assistant professor of medicine. During World War II he was associated with Dr. Chester S. Keefer in penicillin research of the Office of Scientific Research and Development.

A diplomate of the American Board of Internal Medicine and secretary-treasurer of the Survey of Medical Education; member of the advisory council, National Fund for Medical Education; adviser to the director of the Selective Service System; reserve consultant to the Surgeon General, U.S. Navy, and a member of the Citizens Federal Committee on Education, U.S. Office of Education.

Health Center Links Prevention and Cure

CHARLES F. WILINSKY, M.D.
Executive Director
Beth Israel Hospital
Boston

SIDNEY LISWOOD
Assistant Director
Beth Israel Hospital
Boston

DURING the last third of a century, the wisdom of constructing health centers which would house not only the usual health department activities but also those voluntary agencies whose interests are closely allied with health and related activities has been recognized and accepted. The line of demarcation between prevention and treatment is rapidly disappearing, and the medical profession is in increasing measure practicing both. As a result, the integration and correlation of preventive and curative medicine into an entity of closely allied services is receiving increasing attention.

CHALLENGE TO HOSPITALS

Hospitals and public health leaders may well accept the challenge of integrating all such related activities so that community resources will be utilized to the best advantage for the health and general welfare of the community, and the health center may well be the mechanism for bringing curative and preventive medicine together. This means joint planning of hospital and public health programs and the use, where possible, of joint housing, personnel, equipment and administration, to which we must add the joint operation of common departments, such as clinic and outpatient services, records, follow-up services and health education.

There are some problems in effecting this in communities where the hospital may be a voluntary, nonprofit association and the health center is operated under governmental auspices; however, such problems are far from insurmountable. The community operates at a definite advantage when both of these institutions are under the auspices of one group, making the problem of coordinating their activities, both physically and functionally, relatively simpler.

Profound changes and advances in the activities of health departments have paralleled the expansion of hospital functions and services. The achievement and maintenance of ever higher levels of environmental sanitation have made it possible for health departments to turn increased attention toward developing programs to improve individual health through immunization, education and health supervision. At the same time it has been found essential to provide continuing therapeutic services if communicable diseases such as tuberculosis and syphilis are to be effectively prevented. Health departments have begun to recognize the important public health implications of such health problems as cancer, heart disease and other long-term illnesses, and to combat them by providing certain facilities for their early diagnosis.

The decrease in infant mortality, the control of communicable disease, the success of programs to improve maternal and child health, the greater recognition of the rôle of health education—all have served to increase life expectancy and therefore have focused greater attention on the importance of chronic illness as a medical and social problem.

The health center must reevaluate its rôle as a community service in order to determine its participation in developing a program which will meet the changing concepts and requirements, especially in the area of long-term illness.

For example, the agencies whose activities are coordinated within the Boston health units concern themselves principally with the problems of chronic illness. The health department nurse, the visiting nurse, the representatives of the various welfare organizations, all are confronted with this problem when they visit their clients in their homes, or see the people when they come to the health unit offices. We can safely predict that health education, whose emphasis in the past was toward the prevention of disease, in the future will play an increasing rôle in preparing people to overcome the physical and emotional problems of an aging population. Diagnostic and preventive clinics for diseases of the aged, services for those suffering from specific chronic illness, call stations for home care for both acute and chronic illness are all within the range of activity of a well functioning health center.

PUT THEM CLOSE TOGETHER

The principle of coordination has received impetus as the value of home care programs has been recognized not only as a social instrument for improved community service, but also as an effective means of reducing the necessity for hospitalization of those individuals who, under certain determined circumstances, can be treated in the home under the care and supervision of the medical profession. What, then, is more logical than to house both hospital and health department activities in close proximity. By so doing, both the public health and the hospital facilities should be less expensive to provide and maintain, and to a large degree the same technical personnel could serve both activities.

By the joint use of one maintenance and engineering department, one power plant, x-ray department, laboratory and other diagnostic facilities, we can assure economy of personnel, of materials, of maintenance and, more important, of capital investment.

In a health center it is feasible to provide facilities for the outpatient clinics of the hospital as well as for those of the health department. This combination of hospital and health center will not only avoid duplication of certain clinical and diagnostic facilities, but also will increase the possibility of continuity of medical care and supervision with important benefits to the patient. This concept is not a new one and has been developed to a certain degree in Michigan under the aegis of the Kellogg Foundation, as part of its county health department demonstration. These units are called community health centers in Michigan. Strictly speaking, however, these are small hospitals, which incorporate provision for certain health department functions, such as laboratory and home nursing service. The program of a properly constituted health center integrated with the hospital is a significant force in the community, and would establish itself as the rallying point from which total community health activities proceed. Under such circumstances, the health center becomes in fact what in theory it should be—an entity of closely allied medical care and preventive services which combat human illness and promote longer, healthier, happier and more useful living.

PLANNING PHYSICAL FACILITIES

Any health center, constructed now or in the future, should be planned so it will conform to the concept of what a modern health center should be. Its physical organization should be related to its function, and should contain those services which concern themselves with the health problems of the community. Its physical facilities should provide space for the operation of preventive and curative clinics, maintain nursing services, and give real protection with regard to water, milk and food. It should assist in civilian defense and carry on a health education program which reaches the people.

If a health department is inadequately housed and equipped, then it is not only hindered in the performance of its work but it fails to gain the respect its efforts should command. Unstinting public support is engendered not only by the recognition of services performed, but by the manner and circumstances under which they are performed. To perform adequately, the facilities and equipment which are provided should be in keeping with the objectives of the proposed program.

The health center should provide facilities for the following activities:

1. Hospital outpatient clinics.
2. The health department administration and services, which include: (a) public health administration; (b) control of communicable disease; (c) public health nursing; (d) personal hygiene; (e) nutrition and sanitation control; (f) health education, and (g) vital statistics.
3. Voluntary agencies.

We must embrace within this framework such services as maternal and child health care, diagnosis and treatment of tuberculosis and venereal disease, communicable disease immunization, health examination of school children, dental care, public health education, preventive mental hygiene, accident prevention in the home, and inspectional services for milk, food and water, among others.

The joint statement of the American Hospital Association and the American Public Health Association, which concerned itself with the problem of "Coordination of Hospitals and Health Departments" and which was published in 1948, endorsed strongly the integration of preventive and curative services:

"Hospitals and health departments have a common interest in providing the best possible technical facilities and administrative tools for the further development of the preventive and therapeutic aspects of medical practice. The expression of this relationship in terms of greater coordination of the activities of hospitals and health departments has already occurred in some communities, but a great deal still remains to be accomplished in that direction."

In addition, the statement delineated certain areas of common function which could be effectively coordinated between hospitals and health departments. These are:

1. Housing of hospitals and health departments together.
2. Prevention of communicable disease.
3. Program for noncommunicable disease.
4. Maternal and child health.
5. Medical care and hospital services.
6. Hospital licensure laws.

The general statement ended with the following paragraph, which epitomizes the philosophy behind the health center concept:

"It is important at this time that hospital and health department administrators plan to achieve maximum coordination through joint housing, cooperative use of personnel, and the development of active programs to safeguard and promote the health of their community."

The health center, as already stressed, should be so basically constructed as to provide space for the outpatient clinics of the hospital, which are largely curative in nature. An important facet of the clinic arrangement is the provision of adequate waiting room space so that the people coming to the clinic as patients can be cared for with dignity and with consideration of their rights as individuals. The clinics themselves should be so constructed that they will lend themselves to many purposes, and while the function of the outpatient department clinics is in the main curative in nature, the space itself could be used for the preventive services as well. This would involve proper scheduling and coordination between the hospital administration and the health department.

SPACE FOR STAFF OFFICES

Space in the health center should be provided, in proportion to their needs, for the offices of the health department, facilities for staff nurses, the administrative personnel, such as clerical, records and files, the nutritionist, social worker and health educator, the inspectors, the sanitation department, a small laboratory, and public health nursing. In addition, space should be made available for the voluntary agencies which should work closely with the official agencies.

Examples where relationships in varied form have been developed between hospitals and health departments are in order. Among these may be mentioned the following:

1. The Baltimore medical care program. The state of Maryland and the city of Baltimore purchase outpatient care for the needy and medically needy of that area from the voluntary hos-

pitals of Baltimore on a per capita basis.

2. In Bremerton, Wash., the health department has its office and clinics in the voluntary community hospital.

3. In Los Angeles, a small emergency hospital has been added to the district health center.

4. The multiphasic screening program of the Department of Public Health of Massachusetts is an excellent example of an official agency's using the facilities and personnel of a voluntary hospital. The official agency, in this case the Department of Public Health of Massachusetts, instituted a program at the Boston Dispensary which provided screening and diagnostic services to individuals at no cost. Included in this program is a history and complete physical examination, including chest x-ray, blood and urine tests, rectal examination, and so on.

5. The Boston health units, of which there are 10, constructed and staffed under the auspices of the Boston health department, provide facilities and office space within each health unit not only for the usual health center activities concerned with the prevention of disease and the promotion of health and health education, but also for voluntary agencies engaged in health and welfare work, such as the department of public welfare, the Protestant, Catholic and Jewish relief agencies, the tuberculosis association, and others. The Boston health units also serve as call stations for the home care programs of the Boston Dispensary. Needy individuals who cannot afford a private physician may call any one of these health units. The health unit, in turn, will arrange with the Boston Dispensary, a voluntary institution, for a physician active in the home care program to make a home visit.

6. Approximately 250 applications for health centers have been approved under the provisions of the Hill-Burton Act, and about 50 are being planned in combination with hospital facilities.

7. At the present time, approximately 24 examples exist in this country of joint housing of hospitals and health centers, with joint use of personnel and facilities. Of these 24, the combination is with public hospitals in 16 instances and with voluntary hospitals in eight.

8. In areas where the hospitals have medical school affiliation, such as Boston; Birmingham, Ala.; Cook County, Chicago; Denver, and Louisville, Ky., the health officer and the staff have responsibility for the teaching of preventive medicine and public health to medical students.

9. In Denver, Louisville, Monterey and Sonoma there is an administrative as well as geographic combination of health department and hospital, with a single laboratory serving both hospital and health department.

10. The specific areas in which the health department and the hospital were jointly housed, that is, either combined in one building or situated adjacent to each other, are as follows: Birmingham, Jefferson County, Alabama; Kern, Monterey, Sonoma and Stanislaus counties, California; Denver; Floyd, Macon-Bibb and Ware counties, Georgia; Cook County, Illinois; Louisville-Jefferson County, Kentucky; Charles, Washington and Wicomico counties, Maryland; Isabella County and Flint, Mich.; St. Louis County, Missouri; New York City; Columbus and Onslow counties, North Carolina; Okmulgee County, Oklahoma; Arlington County, Virginia, and Bremerton-Kitsap and Kittitas counties, Washington.

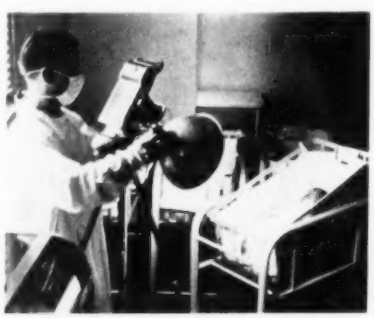
The commodity which modern medical sciences has to offer is the promotion, maintenance and conservation of the individual's health. This requires a close relationship of all kinds of curative services and preventive medicine for the individual, as well as for the mass of the population. The degree to which this can be accomplished may vary considerably from community to community, but the goal is a constant one—namely, better health for all the citizens of the community in which the health center is established. It may thus be summarized in the logical conclusion that a hospital which accepts its rôle as the health center of the community gives the highest type of medical and hospital service. It produces doctors, nurses, social workers and technical personnel—all of whom in turn play an important rôle in rendering the best possible medical care.

Camera Wins Friends and Funds

for Annie M. Warner Hospital

A CAMERA that produces photographic prints one minute after exposure is now in operation in the nursery of the Annie M. Warner Hospital at Gettysburg, Pa. The idea was initiated by a staff member, Dr. Harrison F. Harbaugh, and it has now become an official service of the institution.

The procedure is for Dr. Harbaugh to photograph a newcomer to the world minutes after his arrival, with this new type of camera.



Dr. Harbaugh with new customer.

Later, "Mom" gets a photographic glimpse of her new son. By this time the picture is attractively mounted in a de luxe folder bearing the inscription of the hospital.

According to Dr. Harbaugh, "the parental reaction from the outset has been 'terrific.' Fathers love these pictures too because they can race back to the office with a snapshot of junior to show the gang."

The hospital, which charges $1 for the picture, spends every cent of the money for new luxury equipment for the nursery. The doctor stated:

"It would have taken us years under the regular budget to buy the additional equipment for the nursery department that this camera has made possible in a few short months. It's a top-notch fund raiser and the patients benefit at both ends of the arrangement. They're tickled with the idea."

The Aged Need Protection

from the costs of hospital care

I. S. FALK and AGNES W. BREWSTER

Director and Medical Economist
Division of Research and Statistics
Social Security Administration
Federal Security Agency, Washington, D.C.

NATIONWIDE information is available annually on hospital utilization for the population as a whole. Until late in 1952, however, the corresponding basic facts regarding hospital care among the aged were still being derived from studies made 10 to 20 years ago. In the interim, hospital care has undergone many changes; and the financing of hospital care through insurance has become widespread, affecting the receipt of care in all ages of the population. Current data on utilization are needed to plan health services for the expanding population in the higher ages of life.

MUST BE ABLE TO PAY

Utilization is so linked to ability to pay that it can be understood clearly only in relation to the financing of hospital care, whether for the population generally, among insured and noninsured groups, or among those receiving care at public expense. This is especially true for the aged because they have less than average financial resources and higher morbidity rates.

The pooling of hospital costs—through insurance, taxation or both—is now widely accepted for the financing of short-term care. Insurance plans and companies report that 56 per cent of the population had some kind or amount of hospitalization insurance at the end of 1951.[1] But there has been no reliable estimate of the corresponding per cent among those 65 and over.

To ascertain the current situation about insurance ownership and about hospital utilization among the aged, and to explore possible ways of strengthening their economic security, the division of research and statistics of the Social Security Administration collected all available data from published documents. In addition, Blue Cross plans, retirement plans, public assistance agencies, and others which had age-specific records generously furnished special tabulations. The collected pieces had many limitations, however, with respect to their wider application. To get better nationwide estimates for people 65 and over, the *Current Population Survey* of the Bureau of the Census was utilized. In March 1952 special questions dealing with the ownership of hospitalization insurance and the receipt of hospital care in 1951 were added to the census interview questionnaire, to be asked of or about every person 65 and over in the representative sample of 25,000 households.[2] The replies provided the basis for this study.

The noninstitutional population of persons 65 and over is shown in Table 1, distributed according to age, sex, race, urban-rural residence, and employment status. The per cent that had some hospitalization insurance on the survey date is also shown for each category. Note that 26 per cent of all persons 65 years and over had insurance but that proportionately more men (30 per cent) than women (23 per cent) were insured; and note that there were fewer men than women in the higher ages. The extent of insurance ownership declines markedly with age—36 per cent owned insurance in ages 65-69, but only 15 per cent in ages 75 and over. As a result, the insurance was relatively concentrated in the age group 65-69, the largest age group and the group with the largest proportion still gainfully employed. The proportion with insurance was nearly three times as large among white persons (28 per cent) as among nonwhite persons (11 per cent), and twice as large among urban (30 per cent) as among farm residents (15 per cent). The population 65 years and over is, for the most part, not in the labor force. The percentages with insurance indicate clearly that insurance ownership was directly related to membership in the labor force. There is no question that persons 65 and over lag far behind the rest of the population in the extent of protection available to them.

DATA PERMIT COMPARISONS

Tables 2 and 3 give some key figures on hospitalization among the aged. Data in Table 2 reflect the utilization in 1951 for the March 1952 population and permit comparisons between insured and noninsured persons, as well as among different segments of the aged population of that date. Because of the retroactive nature of the survey, made in March 1952 but measuring hospital experiences in the 12 months of 1951, the data in Table 2 include care received by some persons

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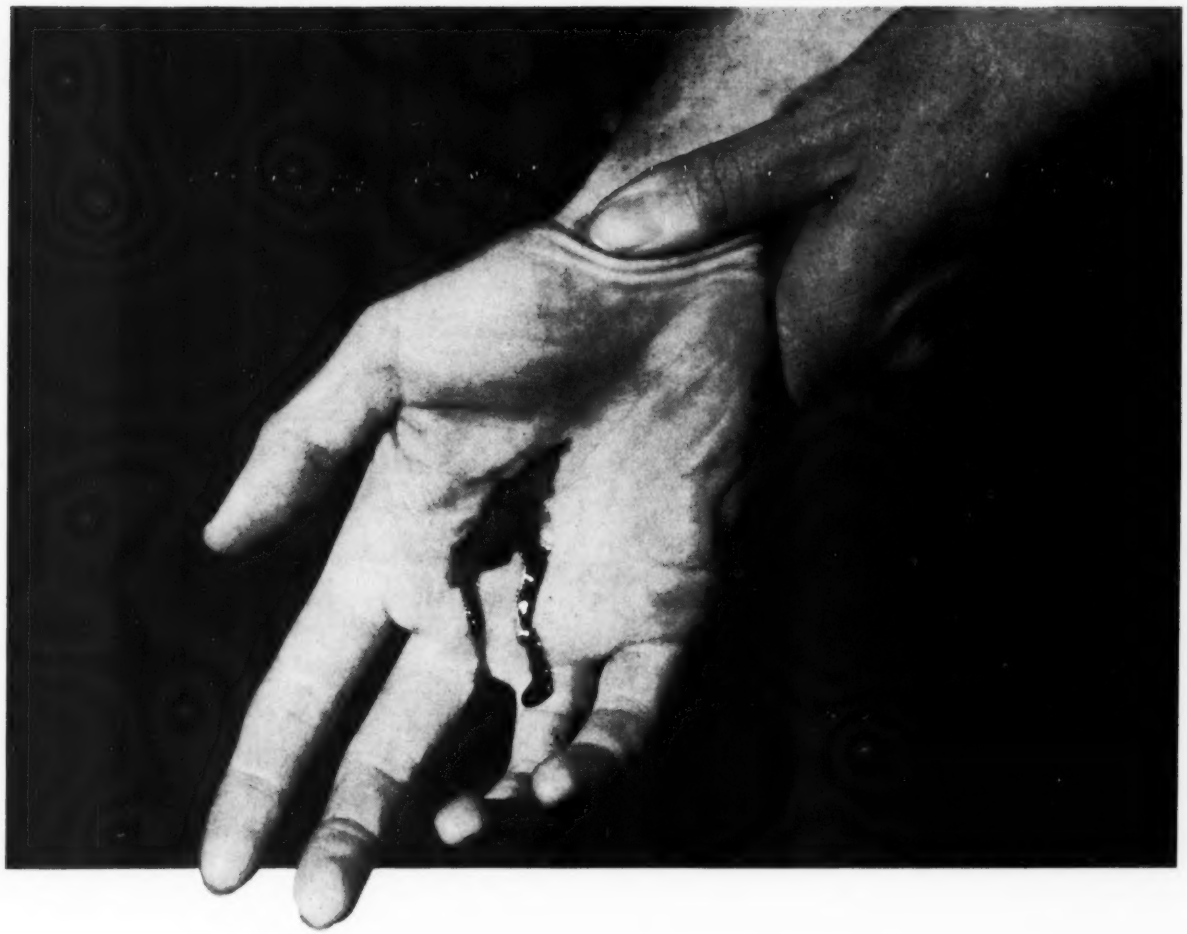
The text of this article is condensed from a paper presented at the annual meeting of the American Public Health Association, before a joint session of the Medical Care Section and the American Association of Hospital Consultants, Cleveland, Oct. 23, 1952.

Opinions expressed here are the authors' and do not necessarily express the views of the Social Security Administration or the Federal Security Agency.



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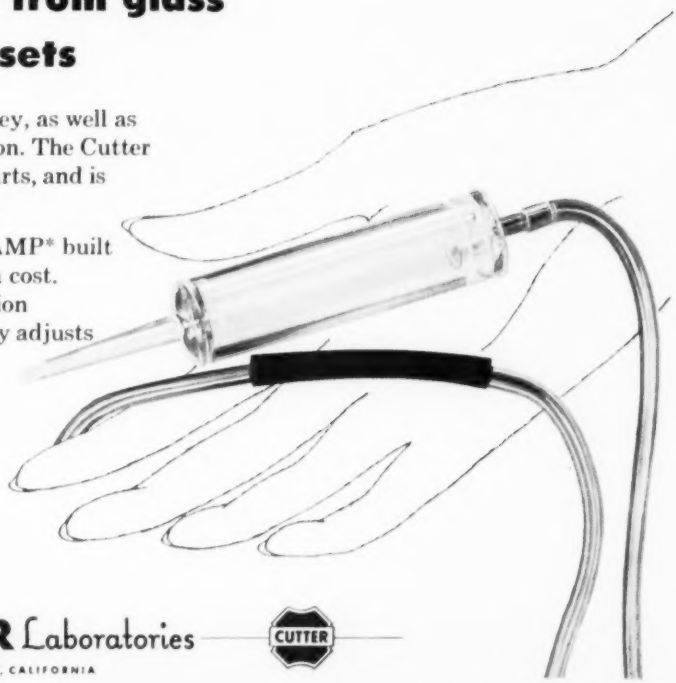

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Table 1—The Aged Population and Ownership of Hospitalization Insurance

Noninstitutional Population 65 and Over, March 1952

Population Group	Number of Persons in Each Population Group (Thousands)			Percentage Distribution			Per Cent With Some Insurance in Each Population Group		
	Both Sexes	Male	Female	Both Sexes	Male	Female	Both Sexes	Male	Female
Total	12,006	5,620	6,386	100.0	100.0	100.0	26	30	23
65-69	4,816	2,338	2,478	40.1	41.6	38.8	36	42	31
70-74	3,343	1,574	1,769	27.9	28.0	27.7	25	28	22
75 and over	3,847	1,708	2,139	32.0	30.4	33.5	15	16	14
White	11,134	5,227	5,907	92.7	93.0	92.5	28	31	24
Nonwhite	872	393	479	7.3	7.0	7.5	11	16	6
Urban	7,640	3,406	4,234	63.6	60.6	66.3	30	36	26
Rural-nonfarm	2,522	1,219	1,303	21.0	21.7	20.4	22	26	18
Farm	1,844	995	849	15.4	17.7	13.3	15	17	14
In the labor force	2,791	2,299	492	23.2	40.9	7.7	44	45	41
Not in the labor force	9,215	3,321	5,894	76.8	59.1	92.3	21	20	21

Table 2—Hospitalization Rates in 1951

Noninstitutional Population 65 and Over, March 1952

	Admissions per Thousand Persons			Hospital Days per Admission			Hospital Days per Thousand Persons		
	All	With Some Insurance	With No Insurance	All	With Some Insurance	With No Insurance	All	With Some Insurance	With No Insurance
Both sexes	73	103	63	22.5	14.7	27.0	1,649	1,506	1,700
Male	82	116	68	22.3	14.6	28.0	1,837	1,685	1,903
Female	65	88	59	22.5	14.7	26.2	1,483	1,297	1,537
White	76	103	66	22.4	14.3	27.1	1,698	1,479	1,781
Nonwhite	41	109	33	25.1	21.8	26.4	1,034	2,369	877
Urban	71	98	60	25.8	14.9	33.6	1,843	1,451	2,014
Rural-nonfarm	82	95	78	19.9	15.2	21.6	1,636	1,443	1,691
Farm	70	152	55	12.4	13.7	11.7	862	2,080	643
In the labor force	64	85	47	12.6	12.0	13.5	806	1,020	637
Not in the labor force	76	114	66	25.0	15.9	29.1	1,900	1,813	1,921

Table 3—Hospital Utilization in 1951

Survey Population 65 and Over, March 1952; and All Persons 65 and Over When Hospitalized

Sex and Age	Admissions per Thousand Persons		Hospital Days per Thousand Persons	
	Survey Population, March 1952[1]	1951 Population (Adjusted)[2]	Survey Population, March 1952[1]	1951 Population (Adjusted)[2]
Both sexes	73	93	1,649	2,051
65-69	78	86	1,406	1,538
70-74	69	89	2,133	2,587
75 and over	71	104	1,530	2,229
Male	82	105	1,837	2,291
65-69	96	105	1,349	1,479
70-74	68	93	2,831	3,366
75 and over	77	117	1,583	2,414
Female	65	82	1,483	1,839
65-69	62	68	1,460	1,593
70-74	69	87	1,509	1,892
75 and over	67	94	1,487	2,080

[1] Confined to the living noninstitutional population aged 65 and over in March 1952.
[2] Includes persons aged 65 and over who died in 1951, and excludes persons who were 64 when hospitalized.

who were only 64 in 1951 and exclude hospital care received by all persons who were 65 and over in 1951 and died during that year and early 1952. The utilization rates adjusted for these two groups are shown in Table 3; this second set of figures therefore reflects the total amount of hospital care received by all noninstitutional persons who were 65 and over at the time care was received.[3] The adjusted rates of Table 3 have the virtue of comparability with hospital statistics as usually presented, being equivalent to rates derived on a current basis. Unfortunately, they do not lend themselves to the comparisons among population groups and between insured and noninsured persons that are possible from Table 2.

Higher admission rates but shorter hospital stays are the general rule for insured—as against noninsured—persons (Table 2). White and nonwhite persons differ in utilization, and there

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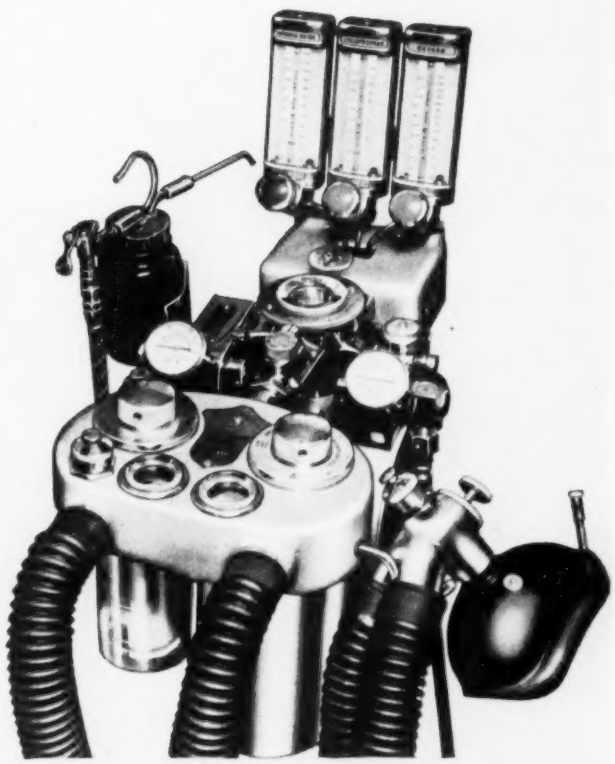

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Table 4—Hospitalized Persons and Days of Hospital Care in 1951 by Duration and Insured Status

Noninstitutional Population 65 and Over, March 1952

Durations	*Total*	*With Some Insurance*	*With No Insurance*
Hospitalized persons, per cent	100.0	100.0	100.0
Receiving less than 31 days	82.8	88.7	79.6
Receiving 31-365 days	17.2	11.3	20.4
Hospital days, per cent	100.0	100.0	100.0
Persons receiving less than 31 days	41.2	65.3	33.7
Persons receiving 31-365 days	58.8	34.7	66.3
Days, to the 31st	20.7	20.6	20.7
Days, beyond the 30th	38.1	14.1	45.6
Hospitalized persons, per cent	100.0	100.0	100.0
Receiving less than 61 days	93.0	97.9	90.4
Receiving 61-365 days	7.0	2.1	9.6
Hospital days, per cent	100.0	100.0	100.0
Persons receiving less than 61 days	59.7	90.6	49.9
Persons receiving 61-365 days	40.3	9.4	50.1
Days, to the 61st	16.7	7.7	19.5
Days, beyond the 60th	23.6	1.7[1]	30.6

[1]No one in this group in the survey sample had more than 90 days during the year.

Table 5—Method of Paying Hospital Bills in 1951

Hospitalized Persons in the Noninstitutional Population 65 and Over, March 1952

Source of Payment	*Total*	*With Some Insurance*	*With No Insurance*
Total	100.0	100.0	100.0
Payment from a single source	76.1	45.4	92.8
By person or spouse	38.1	6.7	55.1
By relative	10.2	1.5	15.0
By insurance	12.6	35.8	.....
By others	1.3	0.7	1.6
No charges	13.9	0.7	21.1
Payment from multiple sources	23.9	54.6	7.2
Payment from single or multiple sources involving:[1]			
Person or spouse[2]	58.8	53.7	61.5
Person, spouse and relative[2]	72.2	62.7	77.3
Relative	18.1	11.2	21.9
Insurance	31.2	88.8	.....
Others	1.6	0.7	2.0
No charges	14.7	1.5	21.9

[1]Not additive.

[2]Also includes a few instances of patient plus free care, relative plus free care, and relative and other.

are contrasts between urban and farm residents in admissions and days of care. The relatively better health that may be presumed for aged persons still in the labor force is reflected in their low rates of admission and short average stays. As a result, their days of hospital care per thousand are much lower than for those not in the labor force, whether insured or not.

In the adjusted data (Table 3), the admission rate for the whole noninstitutional population aged 65 and over in 1951 was 93 per thousand, in contrast to 73 per thousand among the March 1952 population, and hospital days per thousand were 2051 instead of 1649, showing the effect of including admissions and days for aged persons who died during the year or prior to the survey date. In the adjusted data, both the admission rates and the days of care per thousand generally increase with advancing age, reflecting the higher death rates at the highest ages. The male rate of 2291 days per thousand, the female rate of 1839, and the rate for both sexes of 2051 are nearly double the 1951 rate of 1131 for the population of all ages, shown later in Table 6.

The long stays in the hospital of a relatively small proportion of persons can account for a large share of the total hospital days a group receives (Table 4). The insured and the noninsured differed considerably in this respect, however, because only a very small fraction of those with insurance remained in the hospital longer than 60 days and, in the survey sample, none remained longer than 90 days. The figures suggest why insurance plans can, at relatively low cost, increase the maximum benefit days from 21 or 30 to 90, 120 or more. If there were an *un*favorable selection of risk among the insured membership, such as was apparent for aged persons who had no insurance in the March 1952 population, a substantial increase in days of care per thousand would be involved.

Turning to the question of how aged people pay their hospital bills (Table 5), it is evident that the insured and the noninsured met hospital charges quite differently. For 36 per cent of the insured (but for only 13 per cent of the total population) insurance alone took care of the bill; it required supplementation for 53 per cent of the insured. Among the noninsured, 55 per cent met the bill entirely themselves, but more than a fifth had care with no charges made, and relatives met the bill entirely for 15 per cent.

Experiences in furnishing hospital care to persons 65 and over, which were assembled in the course of these studies, are summarized in Table 6. The rates apply to both sexes combined and are based on a wide variety of data. With the basis laid in Tables 2 and 3 for examining differences in rates among different segments of the aged population, the reader acquainted with the characteristics of group payment plans can discover some of the explanations for wide divergence in rates evident among the plans. Limitations of space do not permit more than pointing out that there are differences in age distribution, urbanization, scope of insurance benefits or of public provisions for hospital care, extent of insurance ownership, membership in the labor force, and in availability of hospital facilities and outpatient services. In varying degrees, such factors affect the rates in the different experiences shown. (*Continued on Page* 94)

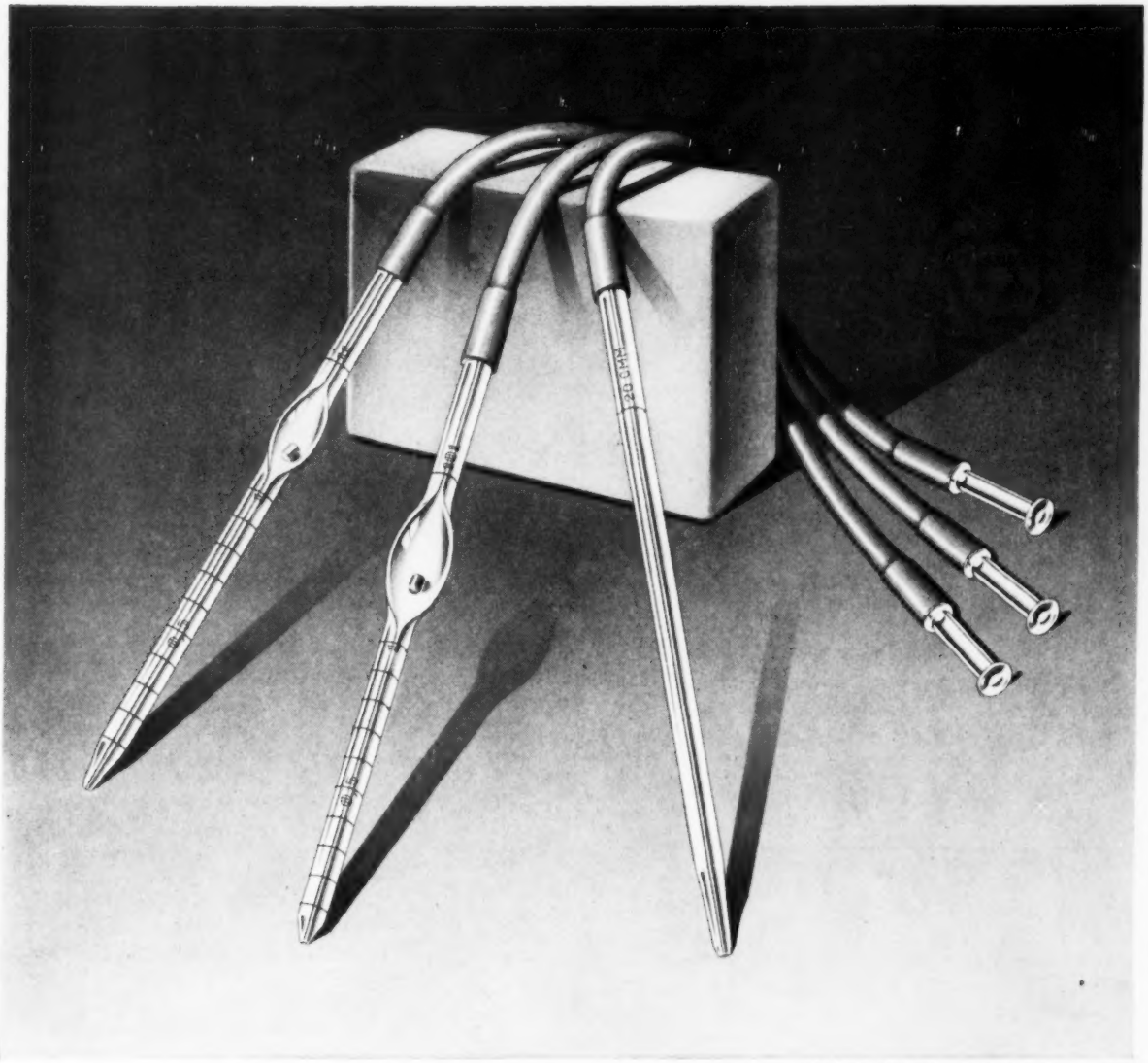

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Table 6—Hospital Utilization Among Persons 65 and Over*

Group	Year	Admissions per Thousand	Days per Admission	Days per Thousand
United States, *all ages*	1951	112	10.1	1,131
SSA—Census survey, 65 and over	1951	93	22.1	2,051
Insured		121	14.8	1,792
Not insured		78	26.8	2,090
Common Costs of Medical Care	1928-31	61	24.6	1,501
National Health Survey	1935-36	50	29.0	1,456
Eastern Health District, Baltimore	1938-43	53	30.0	1,682
OASI beneficiaries, 65 and over	1951	105	25.0	2,620
Insured		130	24.6	3,200
Not insured		97	25.6	2,500
Insurance experiences				
Blue Cross Plans				
A. State, urban-rural	1937-48	138	13.4	1,849
B. State, more urban	1950	174	14.5	2,520
C. Large city and suburban	1950	141	10.8	1,529
D. Metropolitan area	1951	193	12.8	2,473
Other				
H.I.P. members	1948	125	19.1	2,390
Permanente	1950	127	8.2	1,040
GE pensioners	1950-51	163	14.6	2,380
Missouri Pacific pensioners	1949	433	13.5	5,846
OAA, counties in 9 states	1946			
Minimum		72	20.9	1,505
Median		106	25.8	2,735
Maximum		160	40.9	6,544
Canadian public insurance				
British Columbia	1950	172	17.6	3,020
Saskatchewan, 65 and over	1951	334	22.4	7,485
Excluding OA pensioners		303	20.8	6,298
OA pensioners		393	25.1	9,864

*Sources on which these data were based may be obtained from Mr. Falk at the Division of Research and Statistics, Social Security Administration, Washington, D. C.

In 1951, those who were 65 and over received nearly twice as much general hospital care per capita as the population of all ages. This resulted mainly from their relatively high average length of hospital stay. As in other age groups, short-term cases predominated among the aged, but their relatively few long-term cases were responsible for a large proportion of all the days of hospital care they received. This finding invites review of the use of general hospital beds, personnel and funds for the care of long-term cases among the aged.

Among persons 65 and over, the frequency of hospitalization and the amount of hospital care in 1951 varied by age, sex, color, place of residence, and labor-force status, and markedly according to insured status. Since the noninsured are predominantly groups that are presumably worse-than-average risks (they are older; more are retired and unable to work; they include public assistance cases), it may have come as a surprise that they had fewer admissions than the insured. Because of their longer average stays, they nevertheless received a larger amount of hospital care. Thus, financial burden was disproportionately heavy on those least equipped to bear it—those with no insurance protection. These findings are supported by the data showing the extent to which relatives, the hospitals, public agencies, and others—apart from insurance—participated in financing the hospital care of aged persons.

It is widely believed that older persons are not receiving the amount of hospital care they need. This is difficult to test objectively, because "need" is hard to measure. However, if the admission rates for insured persons do not reflect substantial *over*-hospitalization, the much lower admission rates for noninsured persons probably reflect *under*-hospitalization, not only among select groups like the farm residents and the nonwhites, but also among the noninsured generally because as a group they probably have more illness and need more care.

If the aged, and especially the three-fourths among them who were not insured, were *not* receiving all the hospital care they needed in 1951, the implications are very important because their utilization rates were considerably higher than the rates of 10, 15 or 20 years earlier. Will the trend toward still higher levels continue? Should it? Or should more of the care received by the aged, especially by the long-term cases, be of a less elaborate and less expensive kind, whether in institutions designed for bed care, in clinics for ambulatory patients, in doctors' offices, or in patients' homes?

The comparison of the survey findings with those from various other experiences emphasizes that geographical location and factors of population selection radically affect the utilization rates. There are some indications that the hospitalization rates are lower when prepayment applies to a broad spectrum of medical services, and not merely to hospital care. If this observation is supported by further experience, it suggests an opportunity for future reduction in the cost of hospital care, without sacrifice of adequacy, by expansion of outpatient, office and supervised home care of the aged.

The data from old-age assistance experience remind us that the economically neediest among the aged are probably also the medically neediest, and that the amount of hospital care furnished them has been determined largely by available public funds. More nearly adequate provision for public assistance cases throughout the country could involve large additional tax funds. Public assistance methods and practices in regard to hospital care therefore deserve close study, so that there will be maximum economy without sacrifice of quality.

Finally, a few comments on some implications of the data concerning insurance and financing. Only one-fourth of the aged had some hospitalization insurance in March 1952. And those who *had* some, had far less than comprehensive insurance protection—witness their frequent use of other methods and resources to help pay hospital bills. Voluntary insurance may further expand enrollment among the aged and the comprehensiveness of the protection afforded. But the retired status of large proportions of the aged, and the meager financial resources of most of them, suggest limits beyond which self-supporting voluntary insurance may not be able to go in providing the aged with financial security against hospital and other costs of illness.

(*Continued on Page 96*)

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One alternate recourse is public subsidy of current insurance premiums for the aged; but this would involve large amounts of public funds, would call for public standards and accounting, and might be difficult to develop.

Another and perhaps more logical recourse is paid-up hospitalization insurance for those who withdraw from the labor force, and their dependents, and for those still able to work but approaching retirement. If this were provided, the aged would have paid-up insurance for hospital costs just as, under old-age and survivors insurance or other systems, they have paid-up insurance to provide income with which to purchase necessities of life that can be budgeted by individual families.[4] In financial terms, such paid-up insurance implies premium payments during the working lifetime large enough to pay for postretirement as well as for current hospitalization insurance protection. In economic terms, it implies earmarking a portion of current national product for the health services of the aged.

Whatever is done for the future health care of the aged should have regard for economy as well as quality in the hospitalization practices that determine costs; and, at the same time, it should achieve effective as well as equitable allocation of the costs among groups of people and over periods of time.

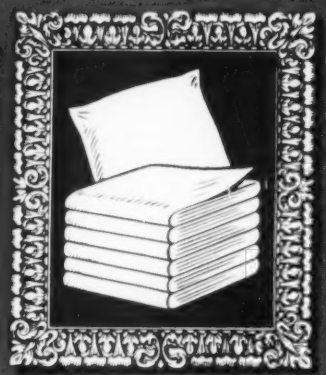
References

[1] Annual Survey of Accident and Health Coverage in the United States, as of Dec. 31, 1951. The Health Insurance Council, New York, June 1952, 31 pp.

[2] For more details on methodology and findings, see Social Security Bulletin, November 1952.

[3] The adjustments for age 64 were based on the hospitalization rates for persons 65-69. The adjustments for decedents were made by applying hospitalization rates, by age groups, to data on deaths according to place of death. It was assumed that: non-institutional deaths had the average frequency and amount of hospitalization of survivors; hospital deaths had one admission of average duration each—to cover terminal and prior hospitalization in the year. We are indebted to the Office of Vital Statistics for use of their punch cards for a 10 per cent sample of all deaths in 1949. Further details concerning these adjustments are given in the Social Security Bulletin, November 1952.

[4] Since this paper was presented, the President's Commission on the Health Needs of the Nation has released its report (Dec. 18, 1952), recommending that "Funds collected through the old-age and survivors insurance mechanism be utilized to purchase personal health service benefits (i.e. hospital and medical care) on a prepayment basis for beneficiaries of that insurance program, under a plan which meets federal standards and which does not involve a means test." (Vol. I, page 48.)



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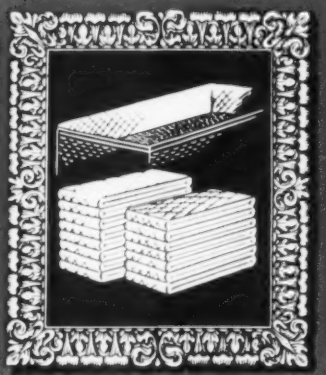

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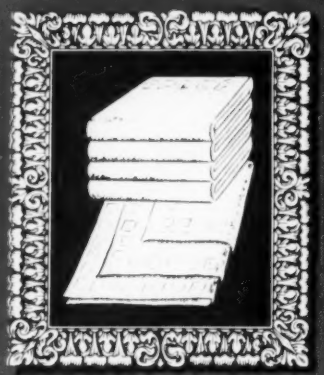

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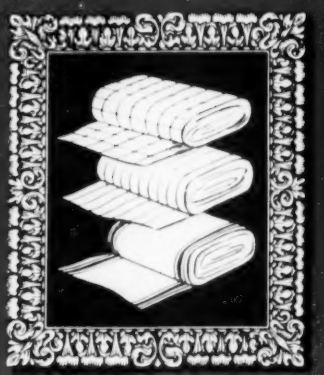

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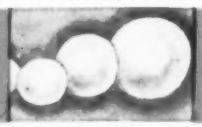

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*Finnerty, F. A., Jr., and Fuchs, G. J.: Washington, D. C., to be published.

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Crawford W. Long and William T. G. Morton

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"So sudden was the advance of anesthetics as an adjunct to surgery, with so much doubt and skepticism had all accounts of such expedients among the earlier surgeons been previously received, that when the accomplishment of such an end was at first announced, it seemed as if something similar to the dream of the philosopher's stone had just been realized."[1]

TRAGIC as it is when the value of a great medical discovery goes unacknowledged until long after the discoverer's death, it is even more distressing when two men—in this case a number of men—earnestly and desperately fight for recognition and honors as the first to make the epochal discovery. After all the authentic documents have been presented and all the commentaries read, each slanted toward a favored candidate, in fairness one can only accord to each claimant his particular share in the honor of having given to the world relief from intense suffering and having made possible the life-saving operations performed in the hospitals of the world today.

Analgesics and anesthetics have been known ever since that first recorded operation: "And the Lord caused a deep sleep to fall upon Adam, and he slept; and He took one of his ribs and closed up the flesh thereof instead."

Inhalation of soothing drugs is described in the earliest documents, including the Ebers Papyrus. The anesthetic properties of the poppy were known to Theophratus (372-287 B.C.), Diogenes, Socrates, Pliny the Elder, Celsus, Diocles and Avicenna. The mandrake (love-apple), belladonna, cannabis indica, hellebore, hemlock, curare, all have their place in the story of ancient analgesics. Each country, each age has its own specifics.

Until the middle of the Nineteenth Century surgery continued to be an agonizing experience to the patient strapped to the table and horrifying to the surgeons who had to witness his suffering. Operations were necessarily few, speedily performed and limited to amputations, breast removal, herniotomy, excision of tumors and plastic surgery. In the five years that preceded the discovery of anesthesia, at the Massachusetts General Hospital only 184 operations were performed.

In the 1830's Sam Colt, seeking funds to patent his new revolver, went about demonstrating "laughing gas" or nitrous oxide. Gas frolics became a popular sport. When late in 1841 (or was it early in 1842?) the

CRAWFORD W. LONG
(1816-78)

WILLIAM T. G. MORTON
(1819-68)

HORACE WELLS
(1815-48)

CHARLES T. JACKSON
(1805-80)

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popular physician, Crawford W. Long, was asked to put on such a demonstration he had no means for preparing the gas, but he knew of something else that would produce the same effect and was harmless, for he had tried it on himself. The ether jag caused much merriment. Long noted that when etherized persons bumped against the furniture they experienced no pain. He wondered whether the ether would dull the pain of his patients when he operated on them.

Crawford W. Long was born in 1816 in Danielsville, Ga. His grandfather, Samuel Long, with his son James, had migrated there from Pennsylvania. James was first postmaster of the village, owned the first store and the first flour mill, and founded the first academy. The boy Crawford was named for an old friend, William H. Crawford, a defeated candidate for the presidency of the United States.

Crawford Long was graduated from Franklin College, later the University of Georgia, in 1835 when he was 14. He studied medicine with Dr. Grant of Jefferson, then at the Transylvania University, and finally at the University of Pennsylvania. After his graduation in 1839 he "walked the wards" of the New York hospitals for 18 months, then settled down to practice medicine in Jefferson. The town was 140 miles from any railroad. Long, then 26, practicing among the environs of the community, forded the streams and day and night drove over the rough roads.

USED ETHER-SOAKED TOWEL

He had decided the night of the ether frolic to try the effects of ether in surgery the first chance he had. On March 30, 1842, he etherized a man named Venerable by holding an ether-soaked towel over the patient's nose and mouth, while he kept his other hand on the man's pulse. As soon as Venerable was insensitive to the prick of a needle, Long painlessly removed a tumor from his neck. For this operation Long charged $2 and 50 cents for the ether. Three weeks later he removed a second tumor from the man's neck.

His chances to operate were few. He removed a tumor from the head of a woman in 1843; he painlessly removed a boy's finger. By September 1846 he had performed only eight operations. Long remarked afterward that had he been practicing in a city where operations were a daily occurrence, he no doubt would have confided in other surgeons. He was a modest man and he wanted to make sure of the efficacy and safety of his new method. Therefore, no one outside his own community knew of his great discovery.

His surprise was great when he read of Morton's similar discovery three years later; even then he waited several years to see if any other surgeon would present a prior claim. In December 1949 he announced his earlier discovery in the *Southern Medical and Surgical Journal*. The controversy in Boston was then raging and Long's claim of priority came like a bombshell.

Had Long sufficiently appreciated the importance of his discovery, had he been less reticent about proclaiming that discovery, the history of modern anesthesia would have been simple and the desperate heartaches among the competitors for the honor of discovery would never have occurred.

He made no claim except priority of actual accomplishment. He wrote: "My only wish is to be regarded as the benefactor of my race. . . . I leave it with an enlightened medical profession to say whether or not my claim to the discovery of anesthesia is forfeited by not being presented earlier, and with this decision which may be made I shall be content."

The properties of nitrous oxide and ether had been known long before their discovery as anesthetic agents was announced. Ether was mentioned by the early Arabians, but it may have come from Egypt like so many of the early drugs. Raymond Lully (1234-1315) made a liquid he called "sweet vitrol"; in 1690 Robert Boyle, "father of chemistry," produced ether but it was pigeon-holed until 1795 when Thornton used pure ether as a sedative and produced anesthesia.

Thomas Beddoes established a "Pneumatic Institute" at Clifton, England, in 1798 for the treatment of disease by inhalation and his assistant Humphrey Davy there became deeply interested in gases and designed various instruments for their use. Doubting Lantham Mitchell's description of the dangers of nitrous oxide inhalation, Davy experimented upon various animals and finally upon himself. The institute closed when Davy left it to pursue his new interest, electrochemistry. Some have spoken of him as the true discoverer of nitrous oxide, for in his "Researches in Nitrous Oxide" he wrote: "As nitrous oxide in its extensive operation appears capable of destroying physical pain, it may probably be used with advantage during surgical operations in which no great effusion of blood takes place."

Not only did Davy fail to go on with what might have proved to be a great discovery, but as president of the Royal Society, he rebuffed Henry Hill Hickman who, after experimentation (1824) on puppies and other animals with carbon dioxide, tried to interest that society in his "suspended animation in surgical operations with carbonic acid gas." Hickman then went to Paris and tried to interest the king, Charles X. However, the members of the Academie de Médecin derided his claims, with the exception of the noted surgeon Baron Larry who became interested and offered himself for the experiment. Defeated, Hickman returned to England and died a few months later at the age of 30. Almost a century later, tribute was paid to this pioneer as a discoverer of anesthesia by inhalation.

COLTON JOINS THE LIST

Another name to be enrolled upon the list of discoverers of anesthesia was that of Gardener Q. Colton. Born in 1814 in Vermont, he briefly studied medicine with Parker of New York, then turned to lecturing on the marvels of chemistry. In December 1844 he was giving an exhibition of "laughing gas" (nitrous oxide) in Hartford and among those who consented to inhale the gas were a young man named Cooley and a dentist, Horace Wells.

Horace Wells, born in Hartford, Conn., in 1815, spent his childhood on his father's large farm at Westminster, Vt. He studied dentistry in Boston in 1834 before the College of Dentistry was established. He began his dental practice in Hartford and having considerable mechanical talent, began to construct and patent some of the dental instruments he used. Distressed by the pain he caused in dental operations, he looked for a means to alleviate such suffering. When Wells and Cooley volunteered for Colton's demonstration, it was noted that Cooley ran against the furniture when under the influence of the gas and when he pulled up the leg of his trousers he was surprised to see blood running down his

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leg, for he had felt no pain. Wells remarked at that time that he believed a tooth could be extracted or a leg amputated painlessly while the patient was under the influence of the gas.

The next morning, against his better judgment, Riggs extracted an upper molar from the jaw of Wells, while Colton administered the gas. Wells, excited over the possibilities or painless dentistry, at once began the manufacture of the gas and tested it further. The following month, January 1845, he went to Boston to consult his former student and partner, William T. G. Morton, about the merits of the gas.

Morton (1819-68), born in Charlton, Mass., had spent a year (1840) in the Baltimore College of Dentistry and in 1841 entered the office of Wells in Boston as a student-assistant. In 1842 the two men formed a partnership but dissolved it within a year. Then in March 1844 Morton entered the office of Dr. C. T. Jackson to study medicine; in November he was admitted to the Harvard Medical School, but never completed the course.

FIRST ATTEMPT A FAILURE

When Wells told Morton of his successful use of nitrous oxide in extraction of teeth, Morton was intensely interested. He had connections at the Massachusetts General Hospital and used his influence to get Wells a hearing. Dr. John Collins Warren, a noted surgeon at that hospital, consented to a demonstration by Wells before his students. Unfortunately, something went wrong with the apparatus and the patient cried out as his tooth was extracted. The students thereupon booed Wells from the amphitheater. Wells quietly continued to extract teeth painlessly in his own office but made no attempt to publish his discovery until December 1846, about six weeks after Morton had announced his own discovery.

Morton had not been disturbed by Wells' debacle. Not being a chemist, he hurried to his former instructor, Jackson, to consult him about the preparation of the gas. This brought the third person into what was soon to be a lengthy and tragic battle, involving Wells, Morton and Jackson, and a little later, Long.

Charles T. Jackson, born in 1805 in Plymouth, Mass., a graduate of Harvard Medical School in 1829, had studied further in Paris and then began to practice medicine in Boston. The effects of ether were not unknown to him when Morton came to consult him. Various stories are told about his first experience with ether, but most writers say that one day when Jackson accidentally breathed pure chlorine gas, he used ether to ease the pain in his lungs and became anesthetized. He declared later that on this occasion he realized the value of such an agent in quieting pain during an operation. However, he did nothing about it.

On inquiry of Morton regarding nitrous oxide, Jackson remarked that it was difficult to manufacture and asked why he wanted it. Morton replied that he wanted to use it in extraction of a tooth. Jackson suggested that he use sulfuric ether as it was easy to obtain, required no apparatus to administer, and had the same effect as the other inhalant. That evening, Sept. 30, 1846, Morton painlessly extracted the tooth of a patient by holding to his nose a handkerchief saturated with ether. A short account of this operation under "Letheon" appeared in a Boston paper the next day.

Morton realized the commercial possibilities of this discovery and sought the advice of a patent attorney and took out letters of patent at once. Since Morton had demonstrated the effects of the anesthetic after Jackson had suggested its use, the attorney decided the patent would have to be issued to the two men jointly. Jackson demurred, since it was held unethical for a physician not to share a medical discovery with his professional brothers, and, moreover, he might lose his membership in the state medical society. Finally, the papers were made out in both names, with the right, title and interest to be issued in Morton's name, and Jackson was to receive 10 per cent of the profits.

Morton was able to persuade Dr. John C. Warren, professor of surgery at Harvard, to test the anesthesia in the Massachusetts General Hospital, just as Wells' nitrous oxide had been tested. On Oct. 16, 1846, the students, together with many important surgeons of the city, gathered in the amphitheater to witness removal of a tumor from the neck of a young man after he had received the new gas, "Letheon." Morton had been perfecting his apparatus and was late, but finally hurried in carrying his instrument, a glass globe about 8 inches in diameter containing the ether, with a mouthpiece and a hole on top closed with a cork. Morton administered the anesthetic and Warren removed the tumor. Warren exclaimed when the operation was over, "This is no humbug." A similar operation was performed the next day and on November 7 a painless amputation was performed.

Morton had hoped to keep the composition of his anesthetic secret but when the staff of the Massachusetts General Hospital refused to use the unknown agent, he revealed that his Letheon was sulfuric ether combined with coloring matter and aromatics. Morton's patent was granted in November 1846 and the following month he received an English patent. That same month Jackson, who had witnessed the first demonstration, published an account in the *Boston Medical and Surgical Journal*. Three days later an interested Oliver Wendell Holmes coined the words "anesthesia" and "anesthetic."

From that time on and for many years, the story of anesthesia is one of bitter quarrels and reprisals. Both Wells and Jackson steadily laid claim to the discovery of anesthesia.

JACKSON CLAIMED PRIORITY

It was no new thing for Jackson to claim priority in some important discovery. When Morse patented his telegraph in 1837, Jackson claimed he had suggested the invention. In 1834 he claimed credit for Beaumont's monumental studies on the gastric secretions because Beaumont had left some gastric fluid with Jackson for chemical analysis of its properties. In December 1846 Jackson wrote a letter to the French Academy of Science claiming discovery of surgical anesthesia and a similar letter to the American Academy of Arts and Sciences in the following March. Morton's demonstration and claims had not been reported in Paris and without investigation the Academie de Paris awarded Jackson 2500 francs. Later, when Morton remonstrated, an equal amount was given him. In 1861 Jackson published a book on nitrous oxide, claiming he had made the discovery very early in 1842. This was after he had visited Long's home and ascertained the month of Long's discovery that year.

Wells went to Paris in 1847 and tried to interest the scientific societies

of that city in his claims and there learned of the previous awards. However, he was received with much favor. When he returned to America he was chagrined to find that ether was now the anesthesia of choice and nitrous oxide had been largely discarded. He became despondent and his erratic deeds finally ended with throwing acid upon the clothes of New York streetwalkers. He was confined in the Tombs and there in January 1848 he ended his life. He was only 33 years old. Twelve days after his death, the medical society of Paris, not knowing of his tragic end, honored him as the first to use the gas successfully in painless surgery. In 1864 the American Dental Association declared Wells the discoverer of anesthesia. In 1870 the American Medical Association passed a similar resolution.

Colton, who first demonstrated the anesthesia to Wells, had meanwhile dropped out of the picture. After making and losing a fortune by divers projects, in 1863 he was again lecturing on laughing gas. With J. H. Smith, a dentist of New Haven, he extracted more than 1700 teeth in 23 days under nitrous oxide. He then set up the Colton Dental Association in New York for the extraction of teeth; by 1868 he had offices in various cities. He died, aged 84, in Holland.

Jackson lived to be 75, but his death was tragic for, upset by his many worries and disappointments, he became deranged and spent the last seven years of his life in an insane asylum.

Meanwhile, Morton too was having troubles. He gave up his lucrative practice, hoping to amass a fortune on his discovery. His is a long story of disappointments. The ether stations he set up did not prosper. When it was known that his anesthetic was ether, no one cared about his patent. Much litigation followed and finally the government refused to recognize the validity of his patent. When congress was about to make him a big grant of money, Jackson upset his claim. Morton received various honors from the University of Baltimore, from Russia and from Sweden and from the Massachusetts General Hospital. The board of trustees of that hospital presented him $1000 in a box inscribed, "He has become poor in a cause which has made the world his debtor."

LONG KEPT OUT OF QUARREL

Until Long showed up as another discoverer of anesthesia, the great quarrel had been among Morton, Wells and Jackson. Although Long had undoubtedly been first in the field, the controversy brought Long no special heartache. He stated his claim and rested his case. Only because his family and friends continued to press his claim was his part in the fight kept alive.

Morton's death was tragic, like those of Wells and Jackson. His wealth swept away during his years of struggle with the government, his creditors pressing heavily upon him, at the age of 49 (1868) he suffered a nervous breakdown in New York City and a congestion of the brain. Jumping from his buggy one day in Central Park, he collapsed against a tree and died before an ambulance could get him to the hospital.

This brief history of anesthesia can hardly close without recognition of Simpson's discovery of chloroform as an anesthetic agent. He was first to use ether in childbirth and thereby called down abuse upon his head by

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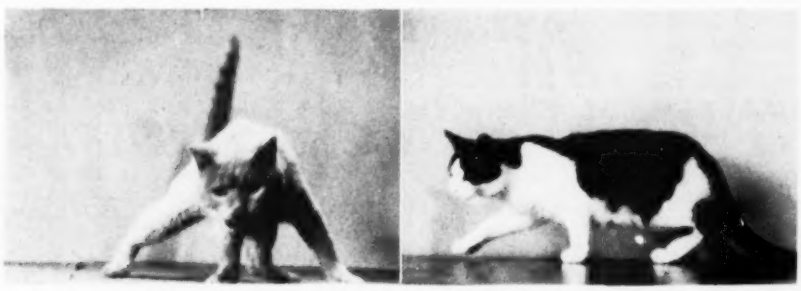

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zealots who believed women had been doomed to suffer in delivery of their offspring. Sir James Y. Simpson (1811-70), the son of a baker of Bathgate, Scotland, had become a world renowned obstetrician and gynecologist. He was one of the first to war against septic fever in hospitals. He had a large obstetric practice. Dissatisfied with ether as an anesthetic and after seeking the advice of Prof. David Waldie, "Master of Apothecaries Hall," Liverpool, he decided to try chloroform as an anesthetic in 1847, one year after Morton's announcement. A public demonstration of its use was successful. Simpson became physician accoucheur to the queen and in 1866 became a baronet. He died in 1870, aged 59.

The art of surgery now developed rapidly and made great demands upon hospital construction. The credit for the discovery of anesthesia, which brought this about, cannot be given to any one man or to two men. Each of the claimants played some part in the discovery. Davy, Colton, Jackson and even Waldie all made helpful suggestions. Long was the first to demonstrate the use of ether as an anesthetic but failed to spread the news. Wells discovered and used nitrous oxide as an anesthetic agent 10 years later (1844) but was too easily discouraged. Each of these men had his advocates as discoverers of anesthesia. Morton is given the credit of discovery by most writers, since he successfully demonstrated the use of ether in surgery and made it known to the world. Finally, Simpson utilized chloroform as an anesthetic, especially in obstetrics.

The discovery of anesthesia entirely changed the practice of surgery. Until its discovery surgery had played a small part in the work of the hospital. Immediately afterward, the teaching of surgery and the development of great surgical departments brought about the greatest change in the modern hospitals.

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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

PYRIDOXINE—An Important Vitamin and Coenzyme

PART I—INTRODUCTION

VITAMIN B_6 was isolated from the water soluble B vitamins by György in 1935. It was called "Factor I" until it was identified as pyridoxine. Now it is known that vitamin B_6 exists in five forms, *i.e.* pyridoxine, pyridoxal, pyridoxamine, pyridoxamine phosphate and pyridoxal phosphate.

Most of the preliminary studies on vitamin B_6 were done between the years 1935 and 1943. In the past few years, interest has been renewed in this subject, particularly in its relation to the enzymatic reactions in body metabolism. We have approached this subject from three points of view: animal deficiency studies, clinical studies in man, and the biochemical consideration of pyridoxine in intermediary metabolism.

ANIMAL DEFICIENCY STUDIES

The existence of vitamin B_6 was established through the use of experimental animals on purified diets. Most of the early animal work was done in the rat. The development in rats of skin lesions which could be cured by "Factor I" led to the isolation and purification of pyridoxine as a separate part of the B complex group of vitamins.

The skin lesions in vitamin B_6 deficient rats have been given the name of acrodynia. This acrodynia was shown to appear at an earlier date and was more severe in rats receiving B_6 deficient diets high in protein. This was one of the earliest indications that vitamin B_6 was important in protein metabolism. Schneider showed that acrodynia could be produced in rats by a diet free from fatty acids and all water soluble vitamins except thiamine and riboflavin. This could be cured by the "essential fatty acids" independent of vitamin B_6. Epileptiform seizures occurred in young rats suckled by pyridoxine deficient mothers. In addition to acrodynia other manifestations of vitamin B_6 deficient rats are necrotic areas in muscle, hyperexcitability, a "ring tail" condition, fatty livers, and corneal vascularization.

In an extensive species survey, the vitamin B_6 deficiency syndrome was found to be ubiquitous. In mice an increased excitability, weight loss but no marked changes in blood picture were noticed. In turkeys, loss of appetite, poor growth, hyperexcitability, convulsions and death were the deficiency symptoms. Chicks showed slow growth, decreased appetite, convulsions and death. Peking ducks showed growth failure and severe anemia. Epileptiform seizures were seen in deficient swine as was a microcytic anemia. A microcytic anemia, loss of weight, intermittent diarrhea, ulceration of the skin, dyspnea and tachycardia were seen in deficient dogs. Rhesus monkeys fed a B_6 deficient diet began to eat less and lose weight slowly after two to three weeks. Gradual weight loss continued for from six to nine months with few changes in external appearance.

With longer periods of deficiency, the animals became unkempt, sluggish, but hyperirritable and showed changes in the hair coat. The constant and most prominent pathological finding encountered in such deficient animals was sclerotic lesions in the arteries of the pancreas, kidney and heart. The fibrous tissue plaques resemble those found in human atherosclerosis. The Syrian hamster showed muscular weakness, loss of luster, and thinning of the hair coat, failure to grow and the early appearance of increased xanthurenic acid in the urine. Death occurred in 12 or 13 weeks. Desoxypyridoxine, an antimetabolite of pyridoxine, will precipitate symptoms of pyridoxine deficiency. The results of such studies have been comparable to those seen in the classical vitamin B_6 deficient states.

Pyridoxine deficiency is chronic in nature, relatively slow in onset, sometimes without distinctive manifestations, and consequently difficult to evaluate.

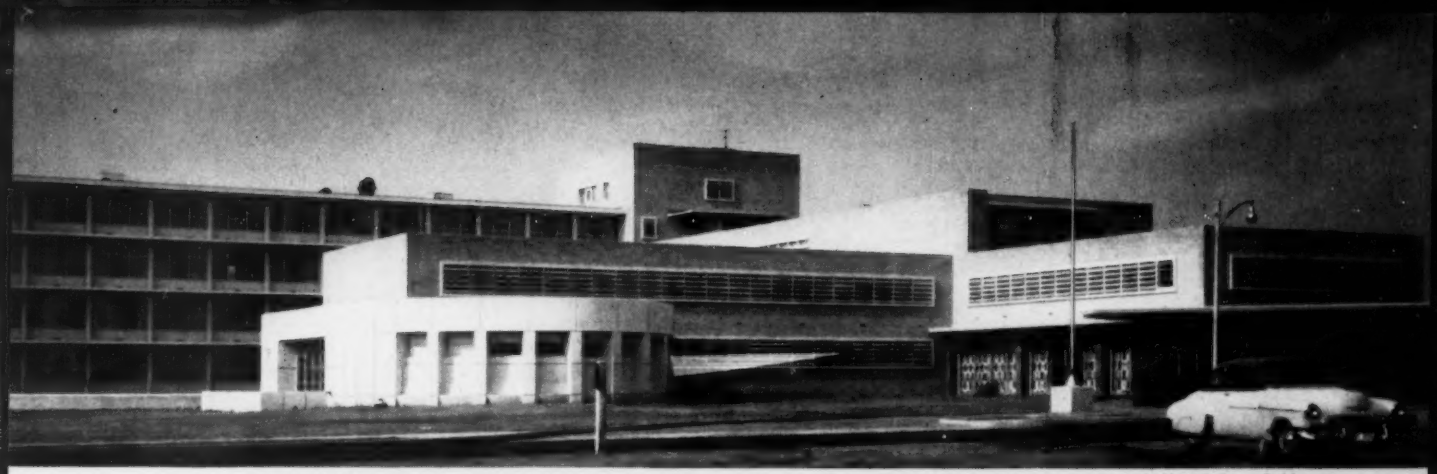
TOXICITY

Unna and Antopol (1940) determined the LD_{50} of pyridoxine in rats, and found it to be 3.1 grams/Kg. for the free base and 3.7 grams/Kg. for the hydrochloride when the compounds were given subcutaneously. The oral toxicity of pyridoxine base was 4.0 grams/Kg. The most consistent sign of acute toxicity was the presence of convulsions preceding death. This is of interest in that convulsions are sometimes seen in the deficiency states. Prolonged feeding of sublethal doses of pyridoxine failed to produce signs of toxicity.

PART II—CLINICAL STUDIES

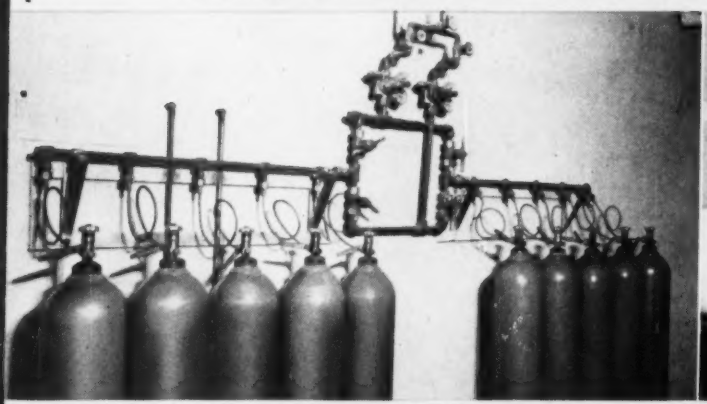
Following the demonstration that deficiency syndromes could be produced in laboratory animals deprived of vitamin B_6, attempts were made to determine if pyridoxine was essential to human nutrition.

In 1939, Spies, Bean and Ashe



The beautiful 96-bed Le Bonheur Childrens' Hospital at Memphis, which was chosen last month as "Modern Hospital of the Year," has been the subject of articles in hospital and architectural magazines.

Architect: J. Frazer Smith and Associates, Memphis, Tenn.



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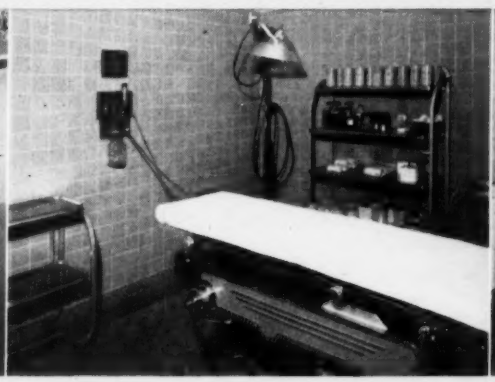
Patient rooms have one bed for a child, one for a parent. Door of NCG combination oxygen-vacuum outlet closes flush with wall.

Anesthesia induction room. Box above outlet is NCG oxygen zoning valve.



Bracket on door of NCG's combination outlet holds suction bottle.

Nursery has separate oxygen and vacuum outlets. All outlets have check valves.

Le Bonheur—"Modern Hospital of the Year" chooses NCG oxygen piping equipment

Le Bonheur Children's Hospital at Memphis, chosen last month as "Modern Hospital of the Year," has aroused nationwide interest in hospital circles—both as a result of its advanced design, and because of its philosophy of nursing care which calls for the continuous presence of a member of the child's family.

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reported on four patients with pellagra and beriberi who, following specific vitamin therapy, exhibited residual symptoms of nervousness, irritability, weakness and abnormality of gait. These symptoms disappeared within 24 to 48 hours after the intravenous administration of pyridoxine. However, Kark, Lozuer and Meiklejohn (1940) were unable to confirm the results of the foregoing investigators in a similar series of cases. Since these early and conflicting results, the importance of pyridoxine in human nutrition has remained an open question.

Hawkins and Barksky (1948) studied the effect of a vitamin B_6 deficient diet on one subject for a period of 60 days. No definite clinical syndrome was observed although the subject complained of depression and mental confusion toward the end of the 60 day period. These symptoms promptly cleared following pyridoxine administration. During the course of the experimental period, the blood urea nitrogen, the total 24 hour urinary nitrogen excretion, the hemoglobin, the white and differential counts, and body weight were followed. The total 24 hour urinary nitrogen excretion and body weight tended to fall near the end of the experiment. A slight drop in white count with a decrease in the number of neutrophils was also noted. Blood urea nitrogen and hemoglobin levels remained normal.

Mueller and Vilter (1950) studied eight hospital patients who received a vitamin B complex poor diet. In addition to this diet, each patient received 60 to 150 mgm. of desoxypyridoxine, which is an antimetabolite to pyridoxine. In 10 to 21 days, all but one patient developed signs and symptoms ascribable to the experimental regime. These signs and symptoms consisted of superficial, scaly, oily and reddened skin lesions, fissures at the angles of the mouth and lateral canthi, a swollen and reddened tongue, and symptoms of nausea, vomiting, dizziness and weakness. All of these manifestations cleared within 12 to 72 hours following intramuscular administration of 100 mgm. of pyridoxine twice daily. Prior to the administration of pyridoxine the patients were treated with thiamine, nicotinamide and riboflavin for four to five days without improvement.

In a recent study, two mentally defective infants were given vitamin B_6 deficient diets for 76 to 130 days, respectively, for "therapeutic reasons." There was a prompt disappearance of pyridoxic acid from the urine and reduction in total urinary vitamin B_6 levels. On the seventy-sixth day of pyridoxine deficient diet one infant developed a series of convulsions which were promptly relieved by administration of pyridoxine. After approximately 130 days, the other infant developed a hypochromic anemia which rapidly responded to pyridoxine.

The foregoing evidence suggests that under experimental conditions man is subject to a pyridoxine deficiency syndrome although clinically such a syndrome has not been demonstrated. It may be that pyridoxine is synthesized in the intestinal tract of man, as studies to be mentioned suggest, and in this way man is protected to some extent from dietary vitamin B_6 deficiencies.

METABOLIC STUDIES IN MAN

Studies on the urinary excretion of vitamin B_6 have shown that pyridoxine is excreted in the urine as pyridoxal, pyridoxamine and 4-pyridoxic acid, the last being the chief metabolic product in the urine. Quantitative studies on the fecal and urinary content of pyridoxine and its metabolites in subjects on controlled vitamin B_6 intake suggest that this vitamin is synthesized in the gastrointestinal tract of man.

TOXICITY

There have been no reports of toxic manifestations to pyridoxine administered either orally or parenterally in the doses used in clinical studies thus far. Total doses of 2200 mgm. have been given over a three-week period without observed toxic effects. Doses of 200 mgm. daily have been given without untoward signs or symptoms.

Weigland, Kekler and Chen noted only local burning and soreness persisting for a period of from 15 minutes to two hours after intramuscular injection of 50 mgm. of pyridoxine hydrochloride.

CLINICAL STUDIES

Although there has been no clear-cut syndrome demonstrated for vitamin B_6 deficiency in man, except in the experimental studies previously discussed, clinical investigators have used pyridoxine in a variety of conditions. The rationale for using this vitamin clinically has been based on the various manifestations of pyridoxine deficiency in animals which have been described previously. The clinical conditions in which pyridoxine has been given a trial are discussed below.

1. Diseases of the Nervous System: On the basis of histological changes noted in muscles of pyridoxine deficient animals, Antopol and Schotland (1940) treated six cases of pseudohypertrophic muscular dystrophy with intravenous and subcutaneous pyridoxine and noted improvement in all six patients. One patient who had improved remarkably on pyridoxine therapy relapsed when a placebo was substituted and subsequently improved when vitamin B_6 was reinstituted. In another case, improvement was temporary as noted by an ultimate downhill course.

Following this early report of success, numerous investigators reported successful trials with vitamin B_6 in progressive muscular atrophy and related conditions as well as in the muscular dystrophies. Other investigators reporting in both English and American literature showed that pyridoxine was of no value in similar cases.

Pyridoxine has also been used with varying reports of success and failure in myasthenia gravis, idiopathic epilepsy, amotonia congenita, anterior poliomyelitis, Sydenham's chorea, and Huntington's chorea.

Jolliffe reported definite clinical improvement in several cases of paralysis agitans treated with intravenous pyridoxine. The cases studied included both idiopathic and postencephalitic Parkinson's disease, the best results being achieved in the idiopathic group. Others report success in postencephalitic as well as idiopathic Parkinson's disease. Clinical studies in which vitamin B_6 failed to alter the course of this disease have also been reported.

Many of the clinical reports dealing with the use of pyridoxine in the neurological disorders are based on only a few cases studied over a relatively short period of time. This fact plus the prolonged and variable course of many of these diseases makes final appraisal of the value, if any, of pyridoxine in many of the foregoing illnesses difficult to ascertain.

2. Diseases of the Skin. Smith and Martin (1940) successfully treated three of four cases of cheilosis with parenteral vitamin B_6.

Jolliffe and his co-workers reported that pyridoxine was of value in the treatment of persistent adolescent acne. They found a significant improvement in those patients receiving vitamin B_6 as compared with a control group receiving placebos.

In the management of seborrheic dermatitis pyridoxine administered parenterally has been reported beneficial by some and of no value by others. Schreiner, Slinger, Hawkins, and Vilter (1952) reported that topical application of pyridoxine to the lesions of seborrheic dermatitis was of value in 22 of 25 cases. However, the lesions tended to recur following the withdrawal of the pyridoxine ointment. The same authors reported that oral and parenteral administration of pyridoxine was without benefit.

Acrodynia in rats which results from pyridoxine deficiency is not to be confused with the clinical syndrome of acrodynia, which Warkany recently has shown to be the result of chronic mercury intoxication. Pyridoxine is not of value in the treatment of human acrodynia.

3. Nausea and Vomiting of Pregnancy. Following the announcement by Willis (1940) that he was able to control nausea and vomiting of pregnancy in 24 of 37 cases with pyridoxine, results of equal success were reported. Weinstein found intravenous pyridoxine therapy highly effective in 29 of 32 cases. Six cases classified as hyperemesis gravidarum were treated with intravenous pyridoxine and improvement was noted in all cases. The same author reported equally good results in a series of 78 cases in which pyridoxine was administered orally.

Although the value of pyridoxine therapy is equivocal in the treatment of nausea and vomiting of pregnancy as it is in many of the other conditions previously discussed, a recent publication by McGanity, McHenry, Van Wyck and Watt (1949) offers objective data suggesting that pyridoxine may be of true value in the management of nausea and vomiting of pregnancy. Normal pregnant primipara have been shown to have lower levels of blood urea than normal nonpregnant females. At least part of this reduction is probably secondary to the hemodilution of normal pregnancy. However, McGanity found the blood urea of patients with hyperemesis gravidarum to be reduced below that of normal pregnancy. When patients with hyperemesis were treated with pyridoxine their blood urea rose to that of normal pregnancy and this was associated with clinical improvement. The blood urea levels of normal pregnant and nonpregnant females was not affected by vitamin B_6.

These authors also observed that when normal pregnant and nonpregnant females were given a test loading dose of an amino acid (dl alanine) the blood urea levels rose to a peak in six hours and returned to the preloading level within 12 hours after the administration of the alanine. In 17 cases of hyperemesis gravidarum the peak blood urea level after alanine loading also occurred at six hours, but in contrast to normal pregnant females remained elevated at the end of 12 hours. After 72 hours of supportive therapy (sedation and I.V. fluids) the blood urea nitrogen was still elevated after 12 hours. However, after 72 hours of supportive therapy plus 120 mgm. of vitamin B_6 the 12 hour blood urea level returned to pretest dose levels as was found characteristic of normal pregnant females. These findings were associated with clinical improvement.

Although these findings do not in themselves explain how pyridoxine acts in hyperemesis of pregnancy they do lend support to the possible value of pyridoxine in this condition. McGanity's results are also of interest with respect to the function of pyridoxine in protein metabolism which is discussed elsewhere in this paper.

4. Radiation Sickness. The favorable results of pyridoxine therapy in the treatment of nausea and vomiting of pregnancy led Maxfield and his coworkers to try this vitamin in radiation sickness in patients receiving x-ray therapy for neoplastic growths. These investigators reported good results in 49 or 50 cases. In both the American and European literature, others have reported favorable results with pyridoxine administered both orally and parenterally. Much of the improvement reported has been on the basis of subjective data gathered on clinic outpatients. Nothing is known as to the action of pyridoxine in radiation sickness which, itself, is not well understood.

5. Postanesthetic Nausea and Vomiting. Bergmann (1947) reported on a series of 24 cases in which 12 cases were treated with 100 mgm. of pyridoxine preceding, and one hour after, surgery. The remaining 12 patients received no pyridoxine and served as controls. None of the patients receiving pyridoxine vomited while all of the control group had an emesis at least once. Ether was the anesthetic in all cases.

Kernis and Stodsky, on the other hand, found no significant difference in the incidence of postanesthetic nausea and vomiting in pyridoxine treated and control patients in a series of 200 cases. The chief differences in the two studies quoted was that pyridoxine was not routinely given postoperatively in the latter series although identical doses were given preoperatively in both series. Also a variety of inhalation anesthetic agents was used in the latter series as compared with Bergmann's cases in which ether was the only anesthetic agent.

***6.* Hematopoietic System.** The observation that pyridoxine deficiency in dogs results in a microcytic hypochromic anemia which does not respond to iron therapy, suggested to Vilter, Schiro and Spies that pyridoxine was perhaps of value in the treatment of certain anemias in man. They treated three pellagrans with macrocytic anemia and two cases of pernicious anemia with parenteral pyridoxine for 10 days without signficant change in the red cell or reticulocyte counts. However, in the two patients with pernicious anemia there was a rise in the white blood count, chiefly in the polymorphonuclear series.

The foregoing effect on the white count stimulated a number of workers to study the response of drug-induced neutropenias to pyridoxine therapy. Cantor and Scott (1944 and 1945) reported on three cases of drug-induced neutropenias, which responded dramatically to pyridoxine. Others (Taylor, 1946, and Fishberg and Vorzimer, 1946) have reported successful use of pyridoxine in the treatment of granulocytopenias secondary to thiouracil therapy. Although the results reported are striking, the groups are small and spontaneous remission secondary to withdrawal of thiouracil cannot be ruled out entirely.

Knutson, Oldfelt and Wising (1946) treated eight cases of chronic benzene poisoning and one case of aminopyrine granulocytopenias with pyridoxine (100-175 mgm./day) for approximately three weeks without improvement.

As a result of reports of lymphoid atrophy in pyridoxine deficient animals, Gellhorn and Jones (1949) placed two patients with lymphosar-

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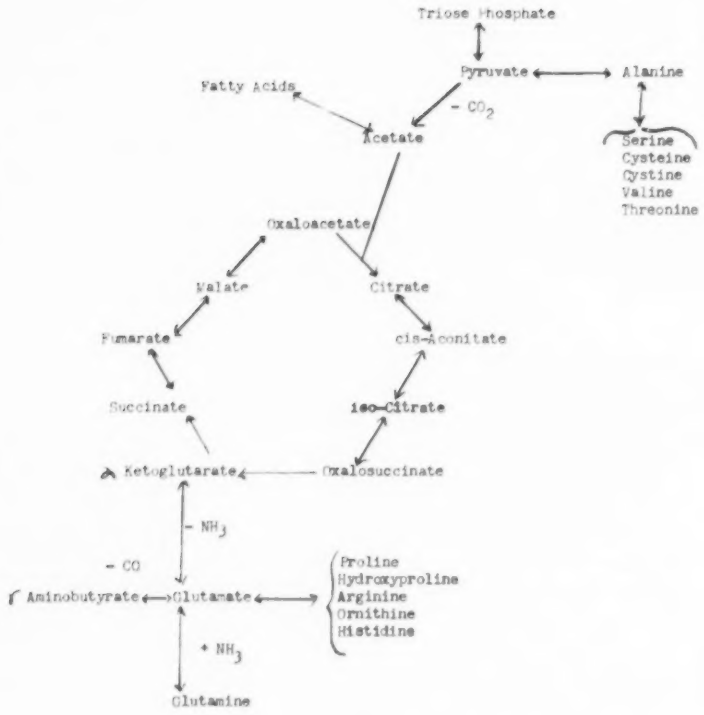

Fig. 1—Krebs' Tricarboxylic Acid Cycle

coma and one with acute leukemia on vitamin B_6 deficient diets plus daily doses of desoxypyridoxine. There was approximately 50 per cent reduction in the size of the lymph nodes in two cases but the course of the disease was not altered.

PART III—BIOCHEMICAL CONSIDERATIONS

The methods employed to assess the rôle of the B_6 group have been nutritional deficiency studies, bacterial growth requirements, and the specific enzyme requirements of respiring excised mammalian tissues as used by the enzymologists. Good correlation has been noted in the data collected from these three sources. Vitamins in general have come to be considered as coenzymes of a variety of enzyme systems. The consequences of vitamin deficiencies are reflected not only in the loss of the specific end products of the given system but also in the toxic manifestations owing to the accumulation of the substrates of the system. In general, the B_6 group has been found to function as a coenzyme for the decarboxylases, the transaminases and the desulfydrases of amino acids. In other miscellaneous conditions, the rôle of B_6 is not well defined. Since the foregoing enzyme systems link protein metabolism to the metabolic pool, a brief description of the cycles involved might be an aid to the visualization of the consequences of hypofunction of these systems.

The Krebs' tricarboxylic acid cycle (coupled with the cytochrome system) is known to be a major site of oxidative phosphorylation, with the carbon skeletons from protein, carbohydrate and lipid metabolism being supplied at key points (Fig. 1). The amino acids glutamic and aspartic enter by being deaminated to a-ketoglutaric and oxaloacetic acids respectively. Arginine, proline, hydroxyproline and histidine can be converted to glutamic acid by other metabolic processes. Monosaccharides are broken down through intermediate stages to pyruvic acid. The latter is then decarboxylated and the two-carbon fragment is presented to the Krebs' cycle to be condensed with oxaloacetic acid to form citric acid. The amino acid alanine, when deaminated, becomes pyruvic acid, thereby creating a third entry point for amino acids to the tricarboxylic acid cycle. The amino acids serine, threonine, cyteine and valine by various processes may all be converted to alanine and thence to pyruvate. Lipid metabolism supplies acetate fragments to be condensed with oxaloacetate.

The distribution of the pyridoxine compounds is ubiquitous in mammalian tissue. Rabinowitz and Snell using microbiological assay methods have characterized the distribution in rat tissues (Chart 1). It is interesting to note that the level of pyridoxine is lower in all tissues as compared with pyridoxal and pyridoxamine. Also, the tissues with the widest metabolic activities, the liver and the kidney, contain the highest concentrations of the group as a whole. The intracellular distribution of the pyridoxine group in liver cells has been reported by Price, Miller and Miller using differential centrifugation for isolation of the cell components and a combination of chemical and microbiological technics for the determinations. They noted that the B_6 vitamins are found in the mitochondrial and supernatent fractions. Recently, these fractions have become associated with the tricarboxylic acid and glycolytic cycles respectively.

The coenzyme function of pyridoxal phosphate was first demonstrated in lysine decarboxylase from Bacterium cadaveris by Gale and Epps. For this function, the compound was named codecarboxylase and is referred to as such elsewhere. In other bacterial systems codecarboxylase was found to function as a coenzyme for tyrosine, arginine, ornithine and glutamic acid decarboxylases. In enzyme systems from mammalian tissues, pyridoxal phosphate was demonstrated as a co-

Chart 1. Distribution of Pyridoxine Compounds in Rat Tissue

	Pyridoxal	*Pyridoxamine*	*Pyridoxine*
Liver	*29.0 ± 3.0	9.0 ± 4.0	9.0 ± 5.0
Heart	16.0 ± 2.0	9.0 ± 3.0	1.0 ± 3.0
Brain	9.2 ± 0.9	4.0 ± 3.0	4.0 ± 2.0
Kidney	33.0 ± 3.0	13.0 ± 15.0	10.0 ± 6.0
Spleen	3.8 ± 0.4	0.7 ± 0.4	0.4 ± 0.8
Sarcoma	2.3 ± 0.2	9.0 ± 1.0	3.0 ± 2.0

*ug/gm wet wgt.
(Rabinowitz and Snell)

enzyme for glutamic acid decarboxylase in brain homogenates. Further, it was found that the development of the central nervous system parallels glutamic acid decarboxylase activity. The end product of this system, gamma-aminobutyric acid, has recently been shown to be present in brain tissue in equimolar concentration to glutamic acid. This fact coupled with the wide function of glutamic acid in transamination and maintenance of ammonia levels through glutamine, as well as supplying a carbon fragment to the Krebs' cycle, opens up unlimited possibilities as to the function of vitamin B_6 in intermediary metabolism of nervous tissue.

Bacteria grown on B_6 deficient media were found to be unable to transaminate glutamic, pyruvic and oxaloacetic acids. Excised tissues from B_6 deficient rats were also unable to transaminate at normal rates. The depression in transaminating ability was found to be a function of B_6 levels in the tissues which, in turn, was dependent upon dietary levels of pyridoxine. Growth in these animals paralleled changes in transaminating ability. Snell and his group, in an effort to determine the exact rôle of pyridoxal in transamination, heated keto acids and amino acids with polyvalent metals and pyridoxal or pyridoxamine and were able to demonstrate transamination in the absence of enzymes. Snell has postulated the formation of a Schiff base complex involving the component parts and has suggested this process as an explanation for the ability of the animals to utilize d-amino acids. As evidence in support of this postulate he found that B_6 deficient animals were unable to racemize amino acids.

The vitamin B_6 complex has an undetermined effect upon the metabolism of tryptophane. Normally, tryptophane has been thought to be metabolized to kynurenine, to kynurenic acid, to 3-hydroxy anthranilic acid, and finally to nicotinic acid. B_6 deficient animals given tryptophane or diets high in tryptophane excreted xanthurenic acid and failed to excrete niacin or N'methylnicotinamide. These animals were also unable to synthesize diphosphopyridine nucleotides (DPN) and triphosphopyridine (TPN) nucleotides from administered tryptophane as compared with normal animals. This inhibition of the synthetic pathway for DPN and TPN assumes even more importance in that the percent-

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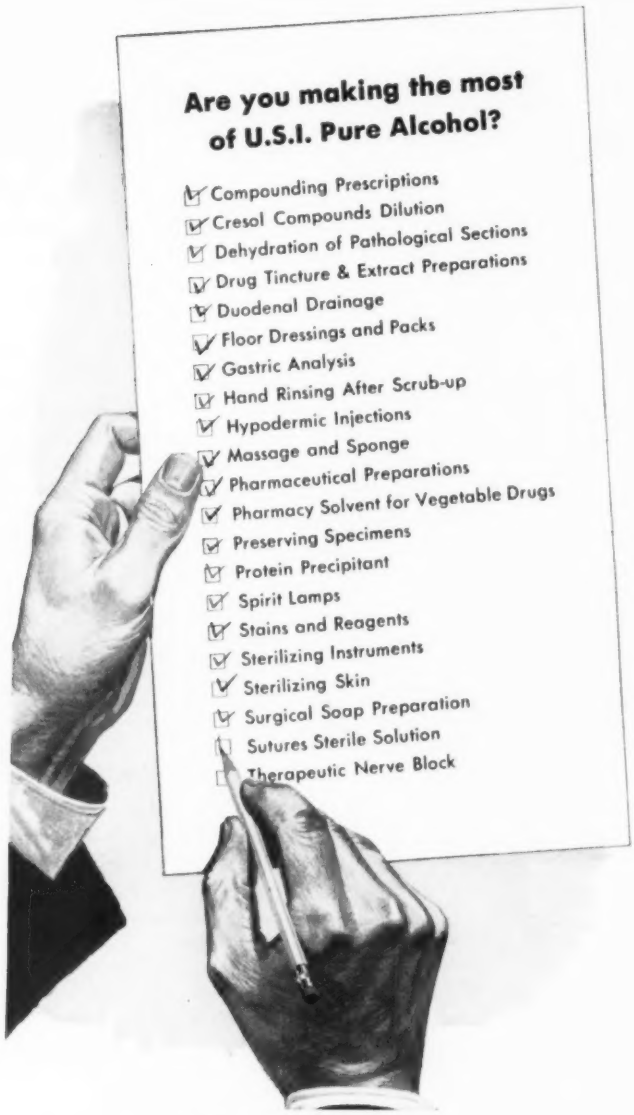

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age of niacin utilized in the synthesis of DPN and TPN as compared with that excreted is greater in normal animals when the source of niacin is tryptophane metabolism rather than when exogenously supplied. This has been considered a possibility for the explanation of the effectiveness of the B_6 compounds in pellagrans.

In sulfur metabolism our knowledge of the rôle of the pyridoxine group also stems from bacterial systems. In the lactic acid bacteria pyridoxal eliminates several amino acids as growth requirements including cystine and cysteine. In B_6 deficient rats fed a low protein diet, cystine, methionine, homocystine and methionine sulfoximine were noted to hasten the appearance of toxic symptoms characteristic of B_6 deficiency, whereas a great number of non-thio acids did not have similar actions in spite of other marked metabolic changes such as that seen on tryptophane feeding. It was suggested that acrodynia, especially marked in the deficiency when the thio amino acids were administered, is in some way related to sulfur metabolism. More recently, evidence has been supplied that pyridoxal phosphate functions as a coenzyme in the sulfur transferring enzymes of mammalian origin. Metzler and Snell have also shown that pyridoxal may function in sulfur transfer in a manner similar to that postulated by Snell for transamination.

Other miscellaneous experiments indicate further implication of the combined effects of the aforementioned systems or possibly other functions of the B_6 group. B_6 deficient animals show increased excretion of glucuronic acid, a regression of thymic and lymphoid tissue, a decrease in antibody formation and a regression in lymphosarcomas as well as increased resistance to implantation of lymphosarcomas. Deficient rats are more susceptible to audiogenic seizures and often have spontaneous epileptiform convulsions.

Despite all the basic information about the function of the B_6 group, little is known of the metabolism of the group itself in mammalian tissues. The active form of the group functioning as the coenzyme has been established as pyridoxal phosphate. The metabolic product of the group has been found to be 4-pyridoxic acid. It is hoped through the use of isotopes and other methods of study, such as tissue culture, more insight may be attained into the ability of mammalian tissues to interconvert and to phosphorylate the three compounds.

PART IV—SUMMARY

After the isolation of vitamin B_6 in 1935 and its identification as pyridoxine (2-methyl, 3-hydroxy, 4, 5-hydroxymethyl pyridine) it was shown to be an essential nutrient for a variety of animals and bacteria. Experimental studies in man suggest that pyridoxine is essential to human nutrition, although a clear-cut clinical deficiency has not been demonstrated. Pyridoxine has been used in the treatment of a number of clinical conditions but the results of these clinical trials are equivocal.

Biochemical investigation has shown that vitamin B_6 is important in protein metabolism. This vitamin acts as a coenzyme in the transamination, decarboxylation and sulfur transfer involving amino acids. As a result of these functions pyridoxine plays an important rôle in integrating intermediary protein and carbohydrate metabolism.—RITA HOCH, B.S., James Preston, M.D., and Keith Killam, B.S.

PORTION CONTROL is the basis of cost control

JANETTE C. CARLSEN
Dietitian in Charge
Johns Hopkins Hospital
Baltimore

PORTION control is the primary factor in establishing an accurate cost accounting procedure. The number of portions obtained from a specified amount of food permits the calculation of the cost per serving; thus all servings must be uniform in size. Such information provides a basis for ordering and predicting the food needs of the institution, as well as aiding in food cost control.

Portion control enables the food manager to plan menus that ensure nutritional adequacy according to the recommended dietary allowances of the National Research Council. These nutritional requirements determine the size of the portions of food offered the patients and the staff of the institution. By calculation the dietitian determines the amounts of food necessary to meet the nutritional recommendations of the National Research Council, and thus establishes the size of the portion to be used, *i.e.* size of the serving of meat, the number of eggs used, the amount of bread, crackers, soup, milk, vegetables, fruit, desserts. This basic diet in the hospital will probably be called the normal, regular or house diet. It will be modified by increasing or decreasing calories, protein, carbohydrate, fat and so on, or changing the consistency as the needs of the patient demand.

Cost conscious dietitians and food workers are interested in portion controls that are practical, attractive, economical and timesaving.

Portion control can be accomplished four ways: (1) by purchasing foods prepackaged or prefabricated in portion sizes desired; (2) by developing standard recipes with the yield calculated in portion sizes; (3) by using standard size containers for serving foods, and (4) by establishing the number of servings of food to be obtained from canned foods.

PREPACKAGED AND PREFABRICATED

Food manufacturers are marketing more of their products in prepackaged and prefabricated units. The advantages of the prepackaged unit are many. Prepackaging provides a sanitary means of handling food, cuts hours of labor spent in packaging and prefabricating in the individual institution, reduces serving time, ensures portion control, and is attractive. However, the dietitian should exercise caution in determining cost of the prepackaged or prefabricated item. The prepackaged item may be more expensive than the bulk item. In areas where labor costs are high the prepackaged or prefabricated food item will probably not be any more expensive than the bulk item. In the small food operation the prepackaged and prefabricated food item may provide a saving and certainly a more efficient operation. In every instance the food manager should carefully compare the cost of the prepackaged item with the cost of the bulk food item, considering the labor cost of packaging and serving, as well as materials used, waste and the attractiveness of the items.

Because of the advantages of prepackaging foods a goodly number of products can be obtained that meet the needs of institutional food services. The majority of biscuit and cracker companies now offer both cookies and crackers in individual packets that meet the demands of their consumers. Dairies offer brick ice cream in individually wrapped pieces, usually six or seven per quart. Very good jellies and jams are now obtainable in three different sizes of disposable, sealed plastic containers.

Perhaps in time the same type of packaging could be used for individual servings of peanut butter, mayonnaise, French dressing, catsup, relish and the like. Until such time, individual paper soufflé cups should be used to assure portion control. Of course, the labor used in filling these cups, as well as the cost of the paper service, should be considered in calculating the cost of the item. Individual packets of sugar, salt and pepper can be obtained which ensure sanitary inexpensive service, plus the opportunity for public relations in printing the name of the institution on the packet. Dry cereals can be purchased in individual serving packages, with several varieties per case if these meet the demands of the institution. Hot drinks and decaffeinated coffee can be obtained in individual packets that are attractive and ensure a standard product upon reconstitution.

In some localities it is less expensive to purchase baked goods from commercial bakeries. Again, it is possible to establish portion control by specifying the size cakes and pies desired and by setting up standards for portion size. Cakes may be purchased by the sheet, round 8 or 9 inch, or square 8 or 9 inch. The sheet or round cake usually cuts to better advantage. Many bakeries furnish cutting guides made of wire to assure even portioning of their 8 or 9 inch pies. The food production manager will always specify the number of slices of bread per loaf; most bakeries maintain similar standards. Milk served in half-pint bottles or paper containers (states may require this by law) is another means of portion control which also affords a sanitary product.

For some time the meat packing companies have been fabricating cuts

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TABLE 1—PORTION STANDARDS

MEAT—BEEF

Food Item	Size Serving	Patient Order	Cafeteria Order	Purchase Unit	A. P. Yield	C. P. Yield	Notes
Patties	4 oz., raw or #10 d.p.	serv.	serv.	lb.		5 serv./lb. 1#/2c. raw	70% meat 30% suet
Ribs							
rolled & boned	3 oz.	serv.	5 serv. per 8 lb./pan	lb.	27-29 lbs.	2½ serv./4 lbs.	
prime	3 oz.	serv.		lb.	21-23 lbs.	2½ serv./4 lbs.	
Standing rib	3 oz.	serv.	5 serv. per 8 lb./pan	lb.	27-29 lbs.	2½ serv./lb.	
Round, bone in				each	72-78 lbs.		24% side wt.
Boneless roast	3 oz.	serv.	5 serv. per 8 lb./pan	each	54-59 lbs.	2½ serv./lb.	18% side wt. 75% round wt. 20% waste trim 45% cooked yield
Round steak sandwiches	5 oz. raw	serv.	40 serv./pan 8 serv./lb.			3 serv./lb.	
Roast beef	2 oz. cooked	serv.	8 lb./pan			6 serv./lb.	
Tenderloin strip	4 oz.	serv.	serv.	each	6 lbs.	3 serv./lb. raw 12 steaks tenderloin	2% side wt. 10% untrimmed 33% loss in trim for steaks
				VEAL			
Breast	4 oz. cooked	serv.	serv.	lb.	5½-9 lbs. single breast	2 serv./lb. raw	50% cooked yield
Chops rib	1 - 4 oz. raw	serv.	serv.	racks	4-6 lbs. single rack	4 serv./lb. raw 18 chops/ single rack	

of meat for use in institutions. The institution may save money purchasing meat that is already fabricated. This, of course, depends on the size of the institution and the cost of the labor in the locality. Small institutions cannot support the services of a butcher, and must therefore expect the cook to fabricate meat when wholesale cuts are bought. This procedure, unless handled by experienced workers, can result in expensive food wastage. It is possible in certain sections of the country to obtain cheese and luncheon meats already sliced for direct use on the cafeteria serving line. Frozen vegetables can be purchased in Nos. ½, 1, 2 and 3 packages. The size most suitable for the food operation should be ordered, consideration being given to desirable vegetable preparation. Vegetable cookery should be staggered so that the nutrients and palatability may be preserved.

Prepackaged staples can be an aid in food preparation if the proper purchase is made. Dried milk powder can be obtained in pound packages, rather than by drum, if the use indicates that less waste will occur with pound packages. Cake mixes and dips are available in No. 1 and No. 5 packages, as well as in large quantities, thus making closer control possible. Prepackaging as a means of portion control has been applied in packaging dishwashing compounds and detergents. These can be purchased in small packets, to control usage and prevent waste.

STANDARDIZED RECIPES

It is not feasible for manufacturers to package or fabricate many types of foods; therefore portion control by the use of standard recipes must be considered. Sound, standardized large quantity recipes have been developed by home economists and food workers. It is no longer necessary for each institution to develop its own. Many of the recipes available can be adapted to the individual institution, thereby eliminating the time-consuming job of recipe development. All standardized recipes must list the yield in servings and the size of the serving if they are to be of use in portion and cost control.

Enforcement of portion control for such food items that result from standard recipes is difficult and requires close supervision. The size of the serving implement should be specified, *i.e.* size of dipper or scoop; if it is a bakery item, the number of servings per pan or the number of pieces should be noted on the recipe card. In the instance of soups and stews the number of ounces per serving should be determined. When these items appear on the menu listing, the size of the serving by the item will refresh the memory of the serving maids and enlist their cooperation in portion control. For roasts the portion size should be established and scales should be made available for weighing the first few portions to reacquaint the serving maid with the amount to give.

These portion controls, once established, provide a basis for ordering of raw food. Meats, for example, can be listed on a single page (see Table 1). Further work can be done to develop the same type of portion control for canned fruits and vegetables, frozen fruits and vegetables, and fresh fruits and vegetables, as well as for such miscellaneous items as mayonnaise, jellies and jams (see Table 2). Once this list is standardized it can be used again and again. The standard portion list should be developed for each institution individually; the portions desired for a children's home are not going to be the same as those desired for a mental institution.

STANDARD SERVING CONTAINERS

Once the standard portion list has been developed supervision is necessary to ensure that the standard size portion is served. Various means may be used to accomplish this. Standard size glasses should be available for pouring and serving juices. Standard size soup bowls will aid the serving maid in adhering to the portion setup. A small serving of food in a large

(*Continued on Page* 126)

Hobart Model L-800 Mixer

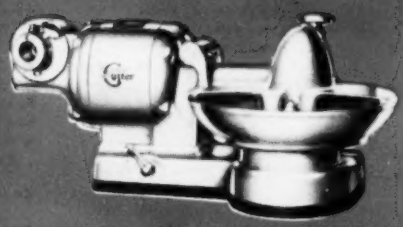

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TABLE 2—PORTION STANDARDS

VEGETABLES, FRESH

Food Item	Size Serving	Patient Order	Cafeteria Order	Purchase Unit	A. P. Yield	E. P. Yield	Notes
Asparagus	3 spears	serv.	30 serv./pan	crate	24 lbs.—12 bunches	3 serv./#	
Beans, lima	½ cup	8/qt.	32/gal.	hamper	35 lbs.	1#-⅔# shelled (1 4/5 cup)	3½ serv./#
Beans, string	½ cup	8/qt.	32/gal.	crate	28 lbs.	4½ serv./#	
Beets	½ cup	8/qt.	32/gal.	crate	3 dz. bunches	3-4 serv./bunch	
Broccoli	1 spear	serv.	30 serv./pan	crate	42-24 bunches	4 serv./#	
Brussels sprouts	6 med.	8/qt.	30 serv./gal.	crate	12 lbs.	5 serv./#	33% waste
Cabbage, green	½ cup	8/qt.	30 serv./gal.	crate	46 lbs.	4 serv./#	30% waste
Cabbage, red	½ cup	8/qt.	30 serv./gal.	crate	46 lbs.	4 serv./#	30% waste
coleslaw	⅓ cup	10/qt.	30 serv./gal.	lb.	46 lbs.	6-8 serv./#	30% waste
Carrots (cooked)	½ cup	8/qt.	30 serv./gal.	lb.	Bu.-50 lbs. bag-50 lbs. or 4-5-6-doz./bunches	3 ⅔ serv./#	
strips (raw)	3 strips	serv.				10-11 serv./lb.	
Celery	1/6 stalk	serv.	serv.	crate-50 lbs.	48 stalks	5 ¾ serv./lb.	
Squash, acorn	½ ea.	serv.					
Tomatoes	¼ ea.	serv.	serv.	lug	28#108 ea.	15.5 serv./lb.	
Turnips	½ cup	8/qt.	30/gal.	bushel	50 lbs.	3 serv./lb.	
Watercress	sprig	serv.	serv.	bunch	1/5 lb.	125/lb.	

VEGETABLES, FROZEN

Asparagus, cut	½ cup	8/qt.	30/gal.	package	2½ lbs.	6 serv./lb.	
Asparagus, spears	5 spears	serv.	serv.	package	2½ lbs.	6 serv./lb.	
Beans, lima	½ cup	8/qt.	30/gal.	package	2½ lbs.	5 serv./lb.	
Spinach	½ cup	8/qt.	30/gal.	package	2½ lbs.	5 serv./lb.	
Squash	½ cup	8/qt.	30/gal.	package	3 lbs.	4 serv./lb.	
Veg. mixed	½ cup	8/qt.	30/gal.	package	2½ lbs.	5 serv./lb.	

VEGETABLES, CANNED

Asparagus, spears	4 spears	serv.	serv.	case	24-12 oz. cans	7 serv./can	
Beans, baked	⅓ cup	serv.	serv.	case	6-#10's	20 serv./can	
Spinach	½ cup	8/qt.	30/gal.	case	6-#10's		
Tomatoes	½ cup	8/qt.	30/gal.	case	6-#10's	24 serv./can	

TABLE 3—PORTION STANDARDS

FRUITS, FRESH

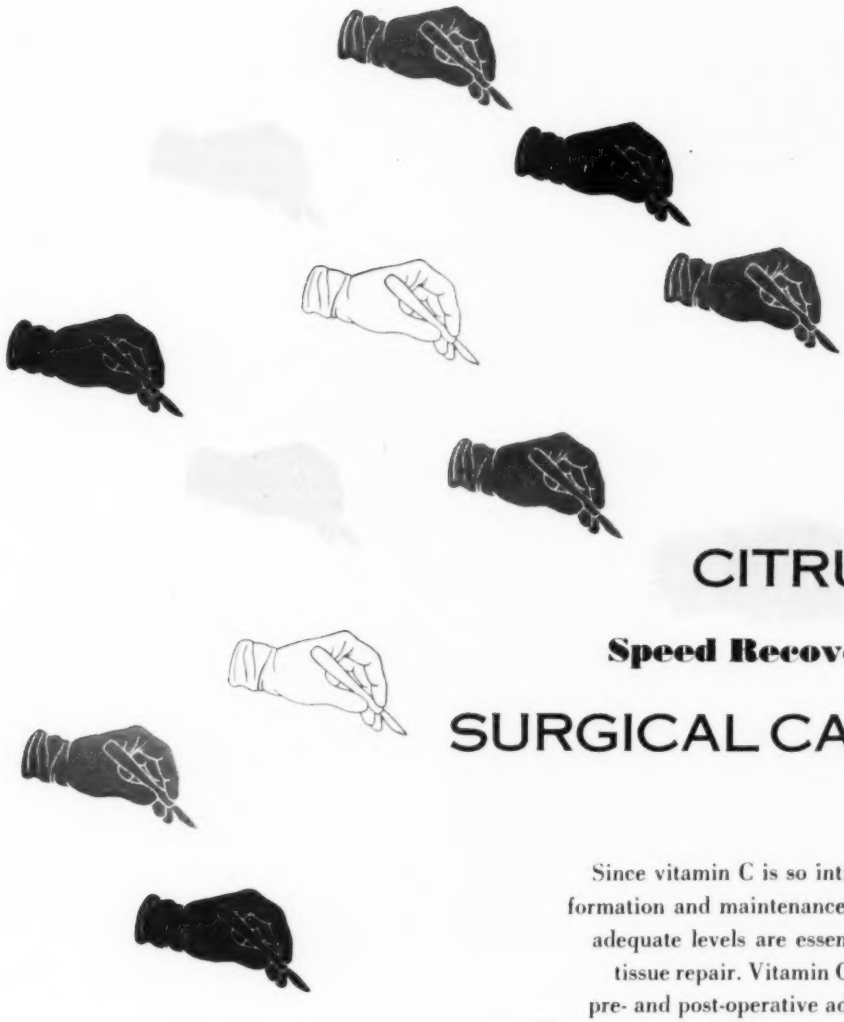
Food Item	Size Serving	Patient Order	Cafeteria Order	Purchase Unit	A. P. Yield	E. P. Yield	Notes
Apples, eating	1 ea.	serv.	serv.	box	42 lbs.	100 serv.	
Apples, cooking	1 ea.	serv.	serv.	bushel	42 lbs.	2½ serv./lb.	
Strawberries	½ pt.	serv.	serv.	pint		4 serv./pt.	

FRUITS, CANNED

Apple butter	1 tbsp.	serv.	serv.	case	6-#10 can	562 serv./can	
Applesauce	½ cup	8/qt.	can	case	6-#10 can	25 serv./can	
Apple, spiced	1 ea.	serv.	serv.	case	6-#10 can	80 serv./can	
Apricots, halves	3/2's	serv.	serv.	case	6-#10 can	26 serv./can	
Blackberries	½ cup	serv.	serv.	case	6-#10 can	24 serv./can	
Blueberries	½ cup	serv.	serv.	case	6-#10 can	24 serv./can	
Cherries, black bing	½ cup	serv.	serv.	case	6-#10 can	20-25 serv./can	
Figs, kadota	3 ea.	serv.	serv.	case	6-#10 can	35 serv./can	
Fruit cocktail	½ cup	serv.	serv.	case	6-#10 can	25 serv./can	
Peaches, halves	2/2	serv.	serv.	case	6-#10 can	20 serv./can	
Peaches, sliced	8 slices	serv.	serv.	case	6-#10 can	30 serv./can	
Peaches, spiced	1 ea.	serv.	serv.	case	6-#10 can	24 serv./can	
Pears, halves	2/2	serv.	serv.	case	6-#10 can	20 serv./can	
Pears, spiced	1 ea.	serv.	serv.	case	6-#10 can	40 serv./can	
Pineapple, sliced	2 slices	serv.	serv.	case	6-#10 can	25 serv./can	
Pineapple, crushed	½ cup	serv.	serv.	case	6-#10 can	25 serv./can	
Plums	3 ea.	serv.	serv.	case	6-#10 can	22 serv./can	

FROZEN FRUITS AND FRUIT JUICES

Apples	½ cup	1 serv.	1 serv.	30 lbs.	30 lbs.	2½ serv./lb.	
Orange concentrate	4 oz.	8/qt.	8/qt.	case	12/case	384 serv./case	
Tangerine Concentrate	4 oz.	8/qt.	8/qt.	case	12/case	384 serv./case	



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bowl is not good salesmanship. Food dispensers are available that also aid in portion control. Cream dispensers can be obtained that are adjustable to dispense ½ or 1 ounce of cream as desired. These, of course, should be approved by the local health authorities. Milk dispensers that dispense only one glass of milk are available. Again these must have the approval of the local health authorities. A new frozen concentrate juice dispenser will soon be available that mixes the concentrate with water in the correct proportions as it is poured. Coffee cups will also be a uniform size. Specified sizes of paper soufflé cups and paper drinking cups are important tools in portion control, as well as an attractive way of serving food.

CANNED FOOD CONTROL

Perhaps the easiest way to begin portion control is to determine the size and the number of servings of food obtained from canned goods. Commercial canneries use standard size cans, and thus it is possible to calculate just how many servings of sliced peaches will be in a No. 10 can, No. 2½, and so on. Again, once the portion has been developed, the chart becomes a permanent reference for the food worker and the serving maid. Revisions keep it up to date and pliable (see Table 3).

There are many advantages to portion control. In order to have accurate cost accounting, portion control must be instituted. Portion control provides a basis for standard ordering procedures and standard serving procedures; it allows close storekeeping control and requisitioning. Prepackaging of food and fabrication of food aids in portion control, whether the work is done in the institution or by the food purveyor. Such treatment of food is more sanitary, is attractive, and cuts food wastage. In purchasing prepackaged food, careful study should be made as to its cost, and the relative merits of the packaging should be weighed against the disadvantages of bulk food. Standardized recipes with the yield in servings developed for the individual institution provide a basis for portion control for those food items not available in package form. Serving utensils, dishes and glasses of known content further aid in portion control. Establishing a portion standard list provides the food service manager with a useful tool in ordering, purchasing, preparation and serving.

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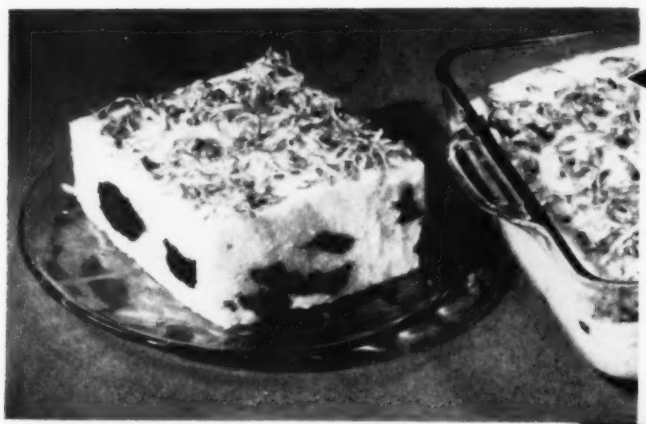


Prune Cheese Cake Bavarian

2 Tbsps. gelatin
½ cup cold juice from Prunes
1 cup hot water
1 lb. dry cottage cheese
1¼ cups sugar
4 Tbsps. lemon juice
1 tsp. vanilla
½ tsp. salt
½ cup chopped, cooked California Prunes
¼ cup crushed dry soya cereal
1 Tbsp. sugar
¼ tsp. nutmeg

Soak gelatin 5 minutes in juice from Prunes. Dissolve in hot water. Sieve cottage cheese and add with sugar, lemon juice, vanilla, and salt to gelatin. Chill until slightly thick; fold in Prunes and pour into 5x9-inch pan. Combine cereal crumbs with sugar (1 Tbsp.) and nutmeg. Sprinkle over top. Chill until firm. Serves 8.

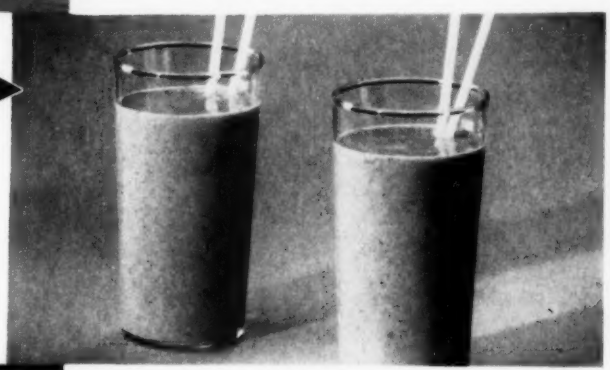
Fat content: 3.35 grams (0.42 grams per serving).
Cholesterol content: 10.1 mg. (1.26 mg. per serving).

Spiced Prune Milk Shake

1 cup cooked, pitted California Prunes
2 cups liquid (juice from Prunes plus water)
6 Tbsps. skim milk powder
¼ tsp. each cinnamon and nutmeg
2 tsps. sugar
Dash salt

Puree Prunes. Combine with juice and water, skim milk powder, spices, sugar, and salt. Beat or shake until well blended. (If using electric blendor, no need to puree Prunes). Serves two.

Fat content: 0.7 grams per serving.
Cholesterol content: 0.8 mg. per serving.



California Prune Fluff

½ cup cold water
1½ Tbsps. lemon juice
½ cup dry skim milk
¼ tsp. nutmeg
1½ cups chopped, cooked California Prunes
3 Tbsps. sugar
⅛ tsp. salt

Combine cold water, lemon juice, and dry skim milk powder. Beat with beater until mixture resembles whipped cream. Stir in nutmeg, Prunes, sugar, and salt. Chill. Makes 6 servings.

Fat content: 1.8 grams (0.3 grams per serving).
Cholesterol content: 2.1 mgs. (0.35 mg. per serving).

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Menus for May 1953

Peggy Hayes
Dietitian
Memorial Hospital
South Bend, Ind.

1 Grapefruit Half Scrambled Eggs, Buns • Baked Fish, Lemon Mashed Potatoes Creamed Peas Gingerale Salad Plums Chocolate Cookies • Lakeside Soup Cheese Soufflé Pineapple Salad Ice Cream	**2** Tomato Juice Cinnamon Toast • Swiss Steak Parslied Potato Broccoli Cottage Cheese Salad Fruit Gelatin • Cream of Mushroom Soup Spanish Rice Wax Beans Assorted Olives Cupcake	**3** Orange Sections Soft Cooked Egg, Roll • Baked Ham With Cherry Sauce Creamed Potatoes, Peas Mexican Corn Molded Lime Salad Chocolate Cake • Navy Bean Soup Cold Cuts Tunafish Salad Potato Chips Lettuce Wedge With Dressing Fruit Cup	**4** Banana Bishop Bread • Minute Steak Mashed Potatoes Stuffed Prune Salad Baked Orange Custard • Baked Italian Spaghetti Asparagus Lettuce, Bacon Salad Ice Cream Sundae	**5** Grapefruit Juice Soft Cooked Egg, Toast • Roast Pork Fried Apples Parslied Potato Spinach, Hard Cooked Egg Twenty-four Hour Salad Angel Cake • Creamed Chipped Beef on Toast Lima Beans Fruit Salad Plate Pineapple Cookies	**6** Stewed Apricots Bacon, Toast • Veal Birds Creamed Potatoes Peas Stuffed Celery Carrot Sticks Banana Icebox Dessert • Beef Noodle Soup Meat Patty in Tomato Sauce Broccoli Pickles, Olives Jelly Roll
7 Tomato Juice Pancakes, Sirup • Baked Ham Mashed Potatoes Green Beans Strawberry Gelatin Salad Lemon Coconut Cupcake • Beef Stew Corn Peach Dream Salad Butterscotch Brownie	**8** Orange Juice Scrambled Eggs, Toast • Salmon Loaf With Pimiento Sauce Parslied Potato Harvard Beets Lettuce Wedge With Dressing Radishes Date, Nut Pudding • Macaroni and Cheese Spinach With Vinegar Dressing Pineapple Waldorf Salad Sugar Cookies	**9** Banana Bishop Bread • Broiled Liver, Bacon Escalloped Potatoes Stewed Tomatoes Under-the-Sea Salad Chocolate Pie • Vegetable Soup Ham Patty With Pineapple Ring Asparagus Spears Celery, Pickles Prune Whip	**10** Honey Dew Melon Sugar Doughnuts • Maryland Chicken Parslied Potato Peas Tossed Salad, Dressing Ice Cream Sundae • Tomato, Rice Soup Meat Loaf With Mushroom Gravy Glazed Carrots Olives Fruit, Cookies	**11** Orange Juice Bacon, Toast • Roast Beef, Gravy Creamed Potatoes Broccoli Banana Gelatin Salad Date, Nut Cake • Chop Suey With Chinese Noodles Green Beans Spiced Peach Salad Chocolate Chip Cookies	**12** Apple Juice Coffee Cake • Minute Steak Mashed Potatoes Baked Onions, Carrots Coleslaw Soufflé Salad Fruit Cup • Chicken, Noodle Soup Sliced Ham, Cheese Ambrosia Salad Cream Puff
13 Grapefruit Half Soft Cooked Egg, Toast • Roast Lamb, Mint Jelly Baked Potato Spinach, Lemon Blushing Pear Salad Apple Cobbler • Mulligatawny Soup Salisbury Steak Asparagus Spring Salad With Dressing Ice Cream	**14** Orange Juice Jelly Doughnuts • Ham Loaf With Pineapple Sections Candied Sweet Potatoes Waxed Beans, Pimiento Molded Lime Salad Vanilla Pudding With Strawberries • Chicken à la King Peas Fruit Plate Salad Lemon Custard Cake	**15** Stewed Prunes Pancakes, Sirup • Fried Fish With Tomato Sauce Parslied Potato Whole Beets Lettuce, Tomato Salad Fruit Gelatin Peanut Butter Cookies • Tomato, Noodle Soup Egg Croquettes With Cream Sauce Mixed Vegetables Pin Wheel Salad Sea Foam Nut Square	**16** Grapefruit Juice Bran Muffins • Swiss Steak Escalloped Potatoes Brussels Sprouts Vegetable Cottage Cheese Salad Chocolate Icebox Dessert • Beef Broth With Rice Manhattan Meat Roll Asparagus Orange Julip Salad Ice Cream Sundae	**17** Banana Sweet Rolls • Fried Chicken, Gravy Mashed Potatoes Creamed Corn Arabian Peach Salad Lady Baltimore Cupcake • Cream of Celery Soup Cold Cuts Egg Salad on Lettuce Potato Salad Pickles, Olives Cinnamon Applesauce	**18** Blended Juice Scrambled Eggs, Toast • Salisbury Steak With Barbecue Sauce Parslied Potato Broccoli Black-Eyed Susan Salad Cherry Cobbler • Chicken Soup Creamed Chipped Beef and Hard Cooked Eggs on Toast Stewed Tomatoes Celery, Carrots Oatmeal Cookies
19 Orange Sections French Toast, Sirup • Roast Beef Stuffed Potato Paprika Cauliflower Whipped Orange Cabbage Salad Raisin Spice Cake • Cream of Mushroom Soup Meat Loaf Spinach Ambrosia Coconut Salad Chocolate Roll	**20** Tomato Juice Blueberry Muffins • Country Style Steak Paprika Potato Green Beans Fresh Fruit Salad Ice Cream • Tomato Bouillon Cubed Beef and Noodles Peas Sunshine Salad White Cake With Almond Sauce	**21** Grapefruit Half Sausage Patties • Pork Chop, Dressing Corn Asparagus Mixed Vegetable Salad With Dressing Baked Fudge Pudding • Broth Baked Chicken, Rice Beets Apricot, Cheese Salad Orange Teaser Cookies	**22** Orange Juice Soft Cooked Egg, Toast • Tunafish Loaf With Tomato Sauce Escalloped Potatoes Lima Beans Lettuce Wedge With Dressing Grapefruit, Peach Roll • Vegetable Soup Salmon Salad Sliced Cheese Potato Chips Green Pear Salad Tapioca Pudding	**23** Cantaloupe Bacon, Toast • Broiled Liver Mashed Potatoes Stewed Tomatoes, Celery Marion Club Salad Marble Cake • Meat Patty With Mushroom Sauce Baked Potato Carrots Mixed Vegetable Salad With Dressing Chocolate Brownie	**24** Grapefruit Half Sweet Rolls • Baked Ham With Mustard Sauce Candied Sweet Potatoes Peas Spring Salad, Dressing Ice Cream • Cream of Celery Soup Macaroni and Cheese With Ham Asparagus Strawberry Cupcake
25 Stewed Prunes Pancakes, Sirup • Minute Steak Parslied Potato Wax Beans Banana, Nut Salad Apricot Upside-Down Cake • Baked Italian Spaghetti Broccoli Fruit Soufflé Salad Chocolate Pudding	**26** Orange Juice Coffee Cake • Roast Lamb Creamed Potatoes Baked Carrots Molded Pear, Cherry Salad Pineapple Fruit Cup • Chicken à la King in Noodle Baskets Spinach With Hard Cooked Egg Fruit Plate Salad Apple Pie	**27** Banana Scrambled Egg, Toast • Veal Birds Mashed Potatoes Harvard Beets Cantaloupe Salad Strawberries in Meringue Shells • Beef, Rice Soup Swedish Meat Balls Peas Bing Cherry Salad Ice Cream	**28** Apple Juice Bacon, Toast • Maryland Chicken Baked Potato Asparagus California Salad Rainbow Cake • Cream of Mushroom Soup Beef Stew Stewed Tomatoes Tossed Green Salad With Dressing Graham Cracker Pudding	**29** Pineapple Juice French Toast, Sirup • Salmon Croquettes With Egg Sauce Green Beans Blushing Pear, Cheese Salad Fruit Cup Cookies • Tomato Noodle Soup Tunafish Salad Sliced Cheese Potato Chips Mixed Vegetable Salad With Dressing Russian Bars	**30** Orange Sections Bacon, Toast • Roast Beef, Gravy Oven Browned Potato Carrots Lemon, Lime Salad Applesauce Cake • Broth Meat Loaf Asparagus Peach Salad Pickles Butterscotch Pudding

31 Orange Juice, Scrambled Eggs, Bacon • Grapefruit Mint Cocktail, Broiled Lamb Chops, Hashed Brown Potatoes, Peas, Molded Pear Salad, Tapioca Cream With Whipped Topping • Cream of Consommé, Sliced Chicken, Corn Fritters, Sirup, Tossed Green Salad With French Dressing, Sliced Peaches, Chocolate Chip Cookies

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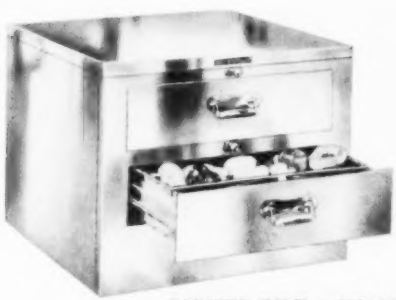

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Yes, you speed service and cut serving costs with the "Toastmaster" Roll and Food Warmer because you can cook a wide variety of foods ahead in quantity for later serving. Actually, foods stay hot and oven-fresh for hours, maintaining their original color and appearance. Since foods are always ready, serving time is shortened. Placing this equipment in floor diet kitchen service eliminates long trips to the kitchen, saves steps for serving personnel.

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Your food service equipment dealer is ready to show you how the "Toastmaster"* Roll and Food Warmer keeps foods hot and oven-fresh for hours, speeds service, and cuts serving costs as well.

TOASTMASTER

Roll and Food Warmers

BEDLIFTER Saves Backs and Budget

FREDERIC G. HUBBARD
Assistant Director
Vancouver General Hospital
Vancouver, B.C.

IN MOST hospitals, lifting beds to elevate patients is an everyday procedure. In many hospitals, however, the lifting of beds is also an everyday problem.

When a doctor orders a patient elevated for one of a number of reasons, the bed must be lifted—a procedure calling for the services of at least two persons.

It is true that special bedlifters have been developed and have been on the market for several years. Certain aspects of these bedlifters, however, were not satisfactory for the particular needs of this hospital. Furthermore, cost is a factor that must be considered by a hospital if it sets out to equip itself with an adequate number of bedlifters.

The Vancouver General Hospital recently decided to provide its nursing services with a number of bedlifters. They had to be reliable and durable—and within the budget. It was also decided to carry out experiments to determine if a "homemade" bedlifter could be developed to meet hospital needs.

The result of the experiments was, literally, just what the doctor ordered.

Vancouver General Hospital's new "homemade" bedlifter is really a very simple apparatus, one that could be made quite easily in the maintenance department of almost any hospital. It consists of an ordinary car bumper jack upon which certain adaptations were made.

Some time was devoted to the selection of a bumper jack that would be easy to operate, would fit any type of bed, would not drop the bed too fast, would be mobile, easy to store and reasonably priced. When the most suitable jack was selected, certain adaptations were made.

First, the arm on the car jack used to support the bumper was not wide enough. To ensure that the bed would be held securely, a supporting arm was added. This arm is simply a piece of cast iron bent to the desired shape and welded to the existing arm of the jack.

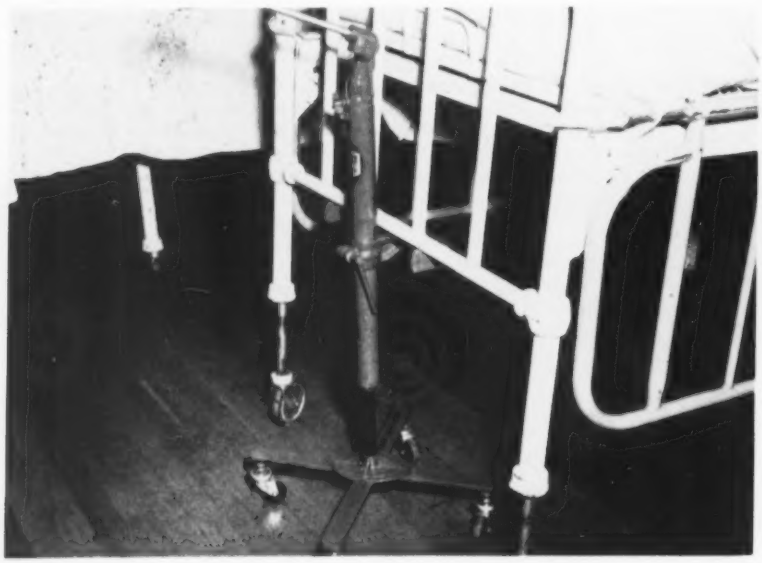
Then, to make the bedlifter portable, two cast iron crossbars were added, and four 2 inch casters were attached to the crossbars. No difficulty has been experienced with slipping when the bed is elevated.

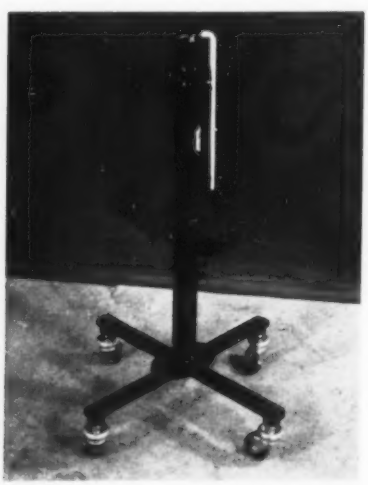
The speed of lowering the bed was next considered. The jack selected had an adjustment knob to regulate the speed of descent. But, rather than run the risk of someone's turning the knob too far, and thus dropping the bed and patient with a jolt, a piece of metal was welded on the knob so it can only be turned a certain distance.

The jack has a removable handle, which, when reversed in its socket, fits neatly against the cylinder of the jack. Storage is therefore no problem.

Perhaps the most pleasing aspect of all was the cost—about half the cost of regular bedlifters. This meant the hospital could supply twice the originally budgeted number of bedlifters—much to the satisfaction of the nursing staff, for lifting beds without a bedlifter is truly a backbreaking procedure.

Below, left: Arm height of the lifter is adjustable for the height of beds in any particular ward. Right: In position for storage.





Conducted by Alta M. Le Belle and Jane Barton

The V.A. Sets Up Housekeeping

TRAINING MANUAL

ON MOPPING—I

FOUR Housekeeping Training Guides, covering sweeping, dusting, waxing and mopping have been developed by the Veterans Administration for use in its hospitals. In this issue, The MODERN HOSPITAL presents the first section of the manual on mopping. The manual on sweeping was presented in the January, February and March issues of this magazine.—ED.

1. Moppy wishes it to be clearly understood that his name is Moppy! His name is *not* Mopey, for he never mopes around. Neither is his name Mucky, for he is careful not to leave any mucky dirt on the floor.

   He is a strong advocate of the "clean floor." He is proud of his title and he will defend it whenever an occasion presents itself.

2. "Cleanliness is second to godliness—I love my work." He works here in the V.A. hospital—and he is proud of his association.

3. Moppy is the middleman on a three-man team. This is only a symbolical three-man team, for in most instances Moppy will be not only a mopper but a sweeper and a waxer too. However, for teaching purposes it will be well to treat this as an individual operation. Nevertheless, the teamwork idea must be put across—for there may be situations where a two or three man floor team may be both feasible and expedient.

4. This diagram emphasizes that a floor must be first swept before it is to be washed. It may be well here to deviate from mopping for a moment and dwell upon the "clean sweep." This clean sweep need not be performed with a broom as the drawing indicates. It could very well be performed with a vacuum or, more correctly, "a suction floor machine." Litter and loose dust must be thoroughly removed from the floor before Moppy begins his work.

5. Again, it should be emphasized that, now that the sweeping has been done, Moppy can go ahead with his mopping operation.

6. Moppy's implication here is that Waxey will not wax a dirty floor. He must always have a clean surface to wax or buff. The instructor must lay stress upon the evils of dust distribution occasioned by buffing, or waxing over floor soils.

7. Moppy again stresses the importance of his work—and its relationship to the many activities of the hospital. He wants everyone to know that his operation—that of keeping the floors clean—is a basic housekeeping requirement. If floors are not kept clean, we cannot expect other areas to meet the standards of hospital cleanliness.

8. This diagram depicts one of the reasons the floors have a bad reputation.

   One type of soil on the floor is carried in on the shoes. The person in these shoes may have walked through mud, or manure, or contaminated sputum, or perhaps just through sand or plaster dust—or any ordinary type of soil. No matter what type of soil it is, it provides work for Moppy.

   If it is just any of the visible soils, such as mud or sand or soot, Moppy's job is to dispose of it so as to provide good appearance.

   The housekeeping service is more likely to be judged on appearance than it is for the reasons depicted in the next diagrams.

9. Here Moppy begins to put over the idea of floor sanitation. Despite the fact that housekeeping service is judged first on the appearance of the floor, its basic responsibility—that of *sanitation*—is of much greater importance than is appearance

   Airborne infections (which can originate from floor soils) can easily develop and be dispersed through the hospital as a result of bad housekeeping.

   The instructor should strongly emphasize that not only the visible soil is to be removed, but also the invisible soils which are contained in all floor soils.

10. Here the principles of airborne infection should be touched upon.

    A simple illustration of how sputum upon a floor dehydrates and becomes a part of the floor soil should be given. The low resistance of the sick patient should be explained and the explanation should be followed by remarks about how much harder it is to combat bacterial invasion during illness than when one is in good health.

    It is also well to point out that Moppy—being in good health himself—is much less likely to be visited by the airborne invasions.

11. Again, inject the mopper's importance to the over-all pattern of keeping the premises "hospital clean."

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12. Here the instructor begins to discuss dirty corners and the importance of a continuous and thorough cleaning program. Corners must not be allowed to accumulate packings of dirt. They must be washed out as thoroughly as is the center of the floor area. It is especially important that corners be hand cleaned prior to the waxing operation for an accumulation of packed dirt, and old dehydrated, brown wax provides a very unsightly mess.

13. The instruction here must include all phases of moving articles (which can be moved) out of the way before the mopping is started.

14. The mopper all too often neglects to include the baseboards, thresholds, wood slatted floor mats, storm runners, and stair risers in his operations. It must be emphasized that these surfaces are also harborages of dirt and bacteria.

15. Moppy wants everyone to know that his job performance is second to none. He is emphatic in his resolve to perform a thorough and a "hospital clean" job.

16. Here the instructor should develop the contrast between "clean floors" and "sparklingly clean floors." The "public relations" aspect of sparklingly clean floors should be pointed out. This aspect reaches far beyond the characters depicted here. It reaches also to the family and friends of the patient who are extremely apprehensive about leaving their loved one in a hospital which is not clean. It reaches to the community—for the community hospital is expected to symbolize a special form of cleanliness.

Moppy is very important in the over-all public relations program of the hospital.

Here it is well to reiterate the reliance which the doctor, the nurse, the dietitian, the technician, and all concerned with patient care place upon Moppy's good performance and his finished job. If Moppy is made to project the importance of the staff's reliance upon having clean floor surfaces he will also project an abundance of job pride along with it. If the worker can be made to have job pride, half the battle will have been won.

17. Here the instructor should stress the importance of cleanliness upon patient psychology. The patient who must gaze at dirty surfaces will become so discouraged as to develop poor morale. Moppy knows full well that good morale will facilitate the healing processes. He gets a lot of satisfaction out of seeing the patients in his area get well faster.

Here the instructor should elaborate upon the inner satisfaction of the worker who has done his job well.

18. (A) The principal theme of this drawing is teamwork.
(B) The secondary theme has to do with the respect of patients, public and staff for well kept property.

(A) Moppy wants to point out here that in order for his other colleagues to do a good job, he must first do his basic job well. He emphasizes that Waxey must have a clean surface upon which to apply his clean wax.

(B) Moppy elaborates upon the high regard everyone has for clean sparkling surfaces. He especially points out that people will help to keep a clean surface looking nice—and conversely everyone will abuse a surface which already appears dirty.

19. Repeat the emphasis on *sparkling* floors and their effect upon the inner satisfaction of the worker, as well as upon public relations and public opinion, and the importance of providing a satisfactory "workshop" for the doctor, nurse and other technicians.

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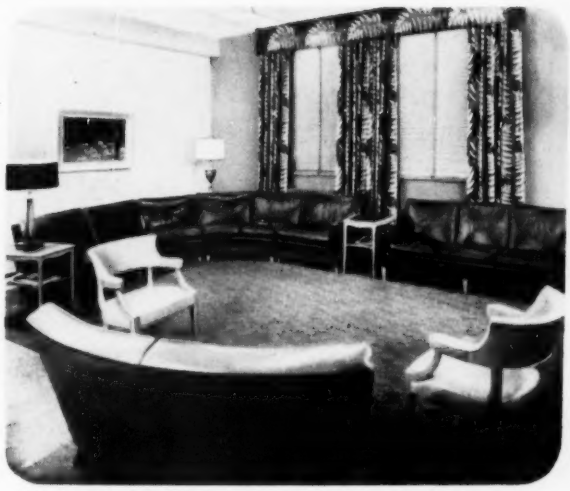

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20. There are many safety hazards associated with the mopping procedures. Moppy derives a great deal of satisfaction from the award he has received for having a good safety record. He will point out the things that he is very careful about.

21. "See what happens when someone steps on a wet floor." The instructor must here elaborate upon the hazards of a damp or wet floor, whether the dampness is caused by one drop of water or a puddle of water.

22. The matter of cleaning up everything that has been spilled, such as drippings from mop equipment, spillage from food trucks, medications, patient accidents, and so on, must also be included in Moppy's safety precautions. He feels a terrific responsibility for moisture of any kind which he finds upon his floors.

He is equally careful about his own "wet" floor processes. He never removes his barricades until the newly washed floor is dry enough to be walked upon without endangering anyone.

23. Moppy emphasizes the importance of "fencing off" the area being mopped. This fencing off process has two purposes: to protect persons from slipping or falling upon the wet or damp floor, and to protect Moppy's clean floor until it has had a chance to dry.

Moppy's barricade may be made up in any of a number of patterns. It should, however, be high enough and colorful enough to attract the eye of the absent-minded person, the preoccupied person, or the person who is in a great hurry.

24. Inclement weather often means repeated mopping in entrances and exits of hospital buildings. Rain, snow and foot soils are quick to mar the appearance of the floor in these areas.

Appearance of floors is always of utmost importance—but safety is more important. On bad weather days Moppy must do many repeat jobs in these areas. He is ever mindful of the sick who must come and go through these entry ways. He is also mindful of all of the others who might easily slip or fall unless these floors are kept dry and clean.

25. He stays "right with it" when the weather is bad. He also stays right with it when new construction or other unusual things dirty up entrances and vestibules, porches and steps.

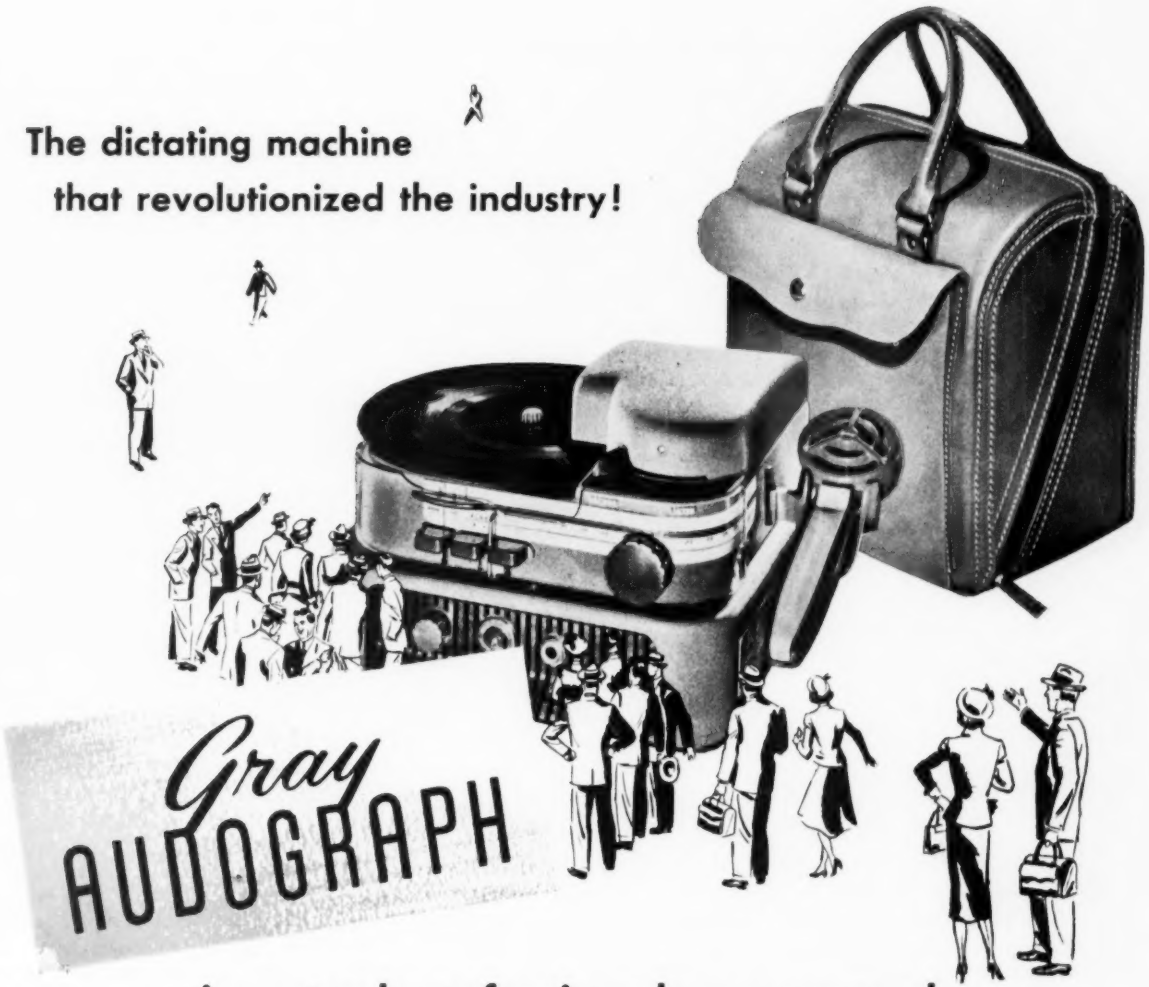
26. Floods of many kinds are the order of the day in most housekeeping departments. They may come from open windows and sudden storms; they may come from broken pipes or from clogged plumbing. Whatever causes them, they bring a hurry-up call for Moppy. It is good to alert him for such emergencies.

27. ". . . and before I can call it quits, I put all my tools away to keep people from falling over them, Safety First—means me"!

Here the instructor must go all out to drill into her students that safety in the placement of materials, equipment and tools is a vital part of Moppy's responsibility.

No mop truck, mop pails, mops or floor machines must be left where they can cause an accident.

The dictating machine that revolutionized the industry!



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Hines—Hospitals Must Be Protected

(*Continued From Page 65*)

of a charity assumes the risk. Today courts hold that negligent treatment is not charity, and that when one with knowledge, skill and capacity undertakes to give service, he is obligated to do so properly. There was a time when, as a matter of public policy, it was felt that an occasional injustice was preferable to a general depletion of charitable funds. However, courts currently hold that public policy is better served when carelessness is discouraged by holding charitable institutions liable. All of these trends are evidence of the fact that hospital administration cannot logically ask the hospital to bear its own risk. The threat of very large financial loss, as well as the substantial expense of legal defense, makes it necessary for the hospital administration to seek another method of meeting the malpractice risk.

CAN TRY SELF-INSURANCE

Another way in which the hospital can meet the malpractice risk is to attempt self-insurance. This should not be confused with the concept of merely bearing the risk, for self-insurance involves definite preparation to meet the losses and expenses arising from malpractice claims by setting aside certain hospital funds as reserves. There are several methods of establishing a self-insurance fund. One is to have the hospital annually appropriate an amount equal to the premiums charged by a private carrier. Another is to study loss experience and expense in an attempt to establish an equitable basis for accumulating a fund. A third system would be to acquire a permanent fund with sufficient interest earnings to meet annual losses—not too practical a method if the difficulty of obtaining funds is considered.

In the operation of a self-insurance plan it is imperative that certain basic principles should not be sacrificed in the interest of making a transient saving. Creation of reserves for normal losses is imperative; so is a predetermined arrangement for extraordinary payments to meet unusual losses. Later in this discussion, the attitude of the insurance companies toward meeting only the catastrophe loss will be described. It is sufficient to point out here that, because of the tremendous expense of litigation in malpractice cases, plus the traditionally large judgments, insurance carriers are not anxious to accept the extraordinary risk only. Also, the self-insurance plan must, of course, provide adequate legal defense. If the interests of the hospital are to be properly protected, either by paid legal talent, which is expensive, or by "donations" of talent from interested lawyers in the community, every claim must be investigated immediately and settlement achieved without delay so as not to increase the hospital's loss.

The most prevalent method of meeting the malpractice risk is to transfer it to a private insurance company. The policy of carrying insurance is a matter of commercial prudence, for the insurance carrier can readily pay the large claim. In addition, the legal and claim services of an insurance company are expert and shift the burden of these difficult duties to more efficient and economical organizations. By employing an insurance company, the hospital removes the uncertainty of loss, thus allowing the hospital to estimate and control financial outlay along prescribed lines. The advantage to a charitable hospital of knowing the "cost" of malpractice in advance cannot be overemphasized.

There is a tendency to object to the cost of insurance, owing partly to the fact that malpractice losses of particular hospitals have often been low compared with the charge for insuring them. Boards and administrators have attempted to decrease insurance costs where this has been true, but their efforts are met with the argument that the possibility of potential loss is so great that insurance companies are reluctant to consider previously good experience too favorably. Furthermore, the insurance carrier must distribute the uneven and uncertain losses of a large number of risks in an equitable manner. The suggestion that hospitals group together and form a reciprocal organization to meet the malpractice risk has frequently been advanced. In a report of its committee on insurance dated June 1949, the American Hospital Association indicated its possible encouragement of this approach unless the insurance industry met the need of separate rating classifications for malpractice, standard rates, and nationwide coverage. In June 1952, the National Bureau of Casualty Underwriters responded to this challenge by publishing a hospital professional liability manual which incorporated the things which the association sought.

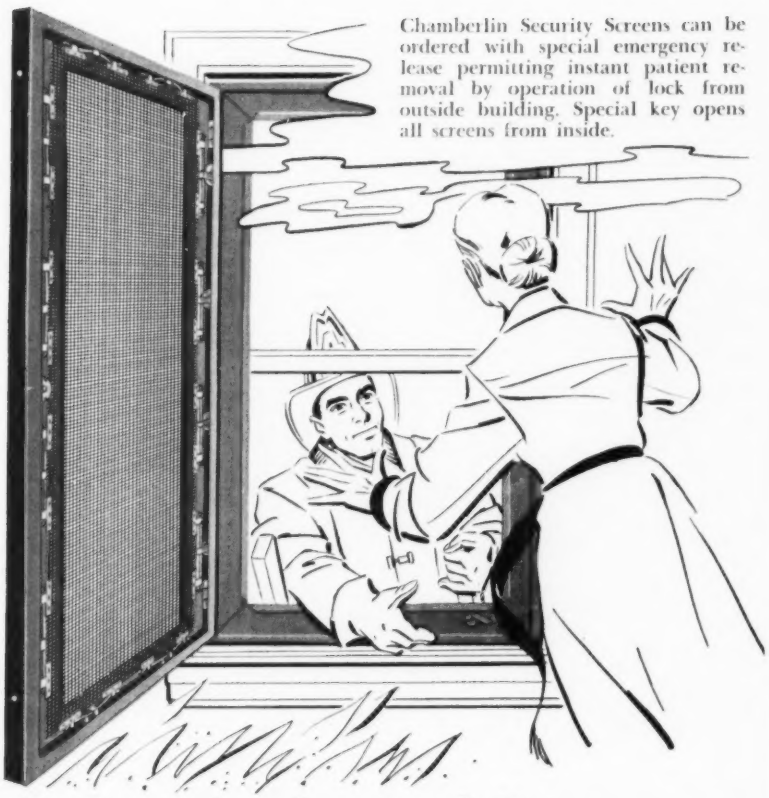
In spite of this recent development, there is still talk about group self-insurance on a reciprocal basis as an alternative to private company insurance. A comparison of these two methods of meeting the malpractice risk shows the reciprocal plan to have certain definite disadvantages. The group fund may not be large enough to pay for losses arising in cases of extremely large claims. There are certain inherent difficulties in establishing and administering such a fund: rivalry among hospitals in the same area, difficulty in investing funds, and inexpert claim adjusting.

MERITS OF RECIPROCAL PLAN

It is obvious that a community group hospital self-insurance fund has only a limited opportunity for selecting risks and none for spreading risks over a large territory. In the very large community this latter argument is reversed, for many hospitals in a large metropolitan area tend to approach, if not exceed in variety, the risks assumed by the insurance companies. Perhaps the reciprocal scheme as applied to such a community would have an advantage over the private insurance company writing a limited volume in that legal decisions and opinions would tend to be approximately uniform. It is also possible that catastrophe insurance—covering an aggregate liability of the total groups—could be purchased to overcome the major objection to a reciprocal plan, inability to meet the holocaust loss or a series of many average losses added together.

An evaluation of the various methods of meeting the malpractice risk indicates that hospitals are still better advised to transfer the risk to an insurance company than to attempt to meet it themselves. An insurance company is, however, reluctant to accept the malpractice risk without the assurance that it will receive a premium which will allow it to pay expected losses and costs of administration, and receive a reasonable profit.

Inasmuch as hospitals have been subjected to the same economic forces in



Chamberlin Security Screens can be ordered with special emergency release permitting instant patient removal by operation of lock from outside building. Special key opens all screens from inside.

Reduce the threat of disaster, too, with Chamberlin Security Screens

You reduce the threat of disaster. No grilles, no bars to trap patients in case of fire. No stubborn or jammed locks to hinder rescue operations. Exclusive Chamberlin locks permit *instant* patient removal from outside in emergencies.

You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

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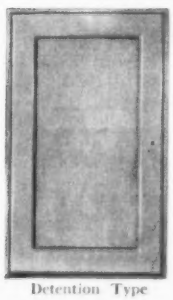
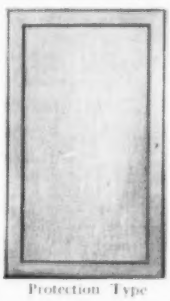


Detention Type



Protection Type

Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for non-violent patients.

QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings: Replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: Prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

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recent years that hotels and similar businesses have encountered, they have been handling more and more patients. The natural result is an increase in exposure. No insurance carrier will face increased hazard without a corresponding increase in rates. The plan, advanced several years ago, for hospitals in certain communities to group their malpractice insurance needs collectively and negotiate with a large insurance carrier for complete coverage does not appear practical as a method of reducing cost. Any insurance company must be properly compensated in a plan of insurance like this, where the cost of coverage would have to be at least the sum of all of its parts.

The hospital professional liability manual published by the National Bureau of Casualty Underwriters provides rules and rates for writing professional liability coverage. From the standpoint of both rates and rules this new manual confirms the previous attitude of the insurance companies toward the cost of writing malpractice insurance and the scope of coverage.

At this point it is appropriate to consider the various factors that govern a hospital malpractice insurance rate. Underwriting "judgment" regarding what rates should be and interpretive analysis of statistical data determine the rates. Large insurance underwriters are able to be scientific in their pursuit of an equitable rate. However, there are other difficulties which complicate the problem of finding a "fair" premium, such as insufficient spread of risk, lack of information relative to similar risks, and deferred claims which slow the maturity of loss experience. All companies, however, have a fairly comparable basis for premium charges. Charges are made on the basis of beds, on a full-pay or part-pay basis, with consideration given to the number of bassinets. The professional staff, as divided into various specialists, dentists, licensed interns, laboratory technicians, types of nurses, and training facilities, is considered, and appropriate charges are rendered. Extra charges for x-ray equipment, radium, pharmacy services, and outpatient clinic visits are used to compute premiums. For purposes of all rating procedures, previous loss experience and reserves set aside to meet pending claims are given special attention.

In answer to frequent complaints of hospital administrators that rates for hospital malpractice insurance are unnecessarily high, an examination of average loss ratios for metropolitan areas show them to be in the neighborhood of 60 per cent—a ratio absolutely not conducive to sound underwriting. Because of this poor loss ratio and because the conditions of legal liability are in a greater state of flux owing to ever increasing judgments, insurance companies are reluctant to cover the hospital malpractice risk.

Many large and reputable American companies will not even consider underwriting hospital malpractice liability insurance at any price while those that do underwrite the hazard insist that they be properly compensated. The underwriters at Lloyd's of London—an insurance market where there is usually some hope of placing difficult risks—share the American market's desire for high rates commensurate with the cost of handling malpractice claims. Neither the Lloyd's underwriters nor American underwriters give favorable consideration to any scheme of excess or partial insurance. As was pointed out, the insurance company wants to control all claims and adjustments, regardless of its participation in the risk, and this

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makes the cost of excess insurance seem excessive. Experience rating, schedule rating, retrospective rating, and premium discount plans applicable to hospital malpractice liability insurance are available for the appropriate risks, but these schemes of insurance contain the same cost factors of bad experience and the desire of the insurance company to handle all claims in which it is involved.

What alternative is there, then, for the hospital administrator who is attempting to keep his operating costs down while he recognizes the need of hospital malpractice insurance? Can he have his cake and eat it too? The answer seems to reside in cooperation between the hospitals and the insurance companies. An exchange of information between the two parties with an attempt of each to understand the problems of the other has already begun with the conferences between the American Hospital Association and the National Bureau of Casualty Underwriters. This cooperation can be translated to the relationships of the individual hospital with its particular insurance company through the hospital's insurance agent. He should know the problems of both parties and his experience should enable him to bring them together on an equitable basis.

The competent insurance agent should work with the hospital to maintain a safety program which has as its objective the reduction of malpractice claims. With better experience the cost of insurance will decline. The agent can work with the insurance company further to scrutinize the rate of insurance. He can use what influence he has to audit the opinion of the underwriter with the hope of familiarizing the insurance company with the operations of the hospital. If this program is effectively accomplished, the hospital will enjoy the security of completely transferring its malpractice risk at reasonable cost.

Hawkins—"The Insurance Industry Is in the Squeeze"

(*Continued From Page 65*)

companies have requested or need, but at least enough to improve the situation. Amazingly, however, the very groups that have benefited most from the companies' accomplishments are protesting energetically in some states. I would like the public, and especially hospital people, to decide whether the problems of our industry are products of mismanagement within or of developments on the outside which were completely beyond our control, but are within the control of an informed and aroused public.

GOVERNMENT WANTS PROOF

When government regulates a business, it demands mathematical proof of the need for price increases before its approval is forthcoming, and it takes a minimum of a year, and frequently more, for insurance statistics to catch up with conditions. What the casualty insurance companies did not and could not foresee were events that were to upset the calculations of the nation's soundest economists. You will recall that economists everywhere expected a business recession back in the months immediately following World War II. In fact, the outlines of a recession actually began to take form. Then our country's program for vast financial aid to Europe developed, overnight we found ourselves at war in Korea, and inflation resulted. Prices for everything skyrocketed. Claim costs rose to an unprecedented level in 1951; losses exceeded $100,000,000.

Were prices of liability insurance out of line with other commodities and services? Since 1939 the commodities price index has increased approximately 89 per cent. For the same period hospital expenses have soared 135 per cent, automobile repair costs, 134 per cent, the price of new automobiles, 136 per cent. The cost of settling claims has increased 150 per cent for property damage and 70 per cent for bodily injury, and in the same period of time the cost of liability insurance itself has increased an average of 35 per cent. In other words, everything that affects the price of liability insurance has increased considerably more than the price of insurance itself. Surely no fair-minded persons will deny that insurance companies have done more to hold the price line than the great majority of other industrial and business enterprises have.

PROFITS ARE SMALL

There is a strange belief abroad that somehow, somewhere, insurance companies have miraculously tapped an inexhaustable well from which dollars flow in endless supply and that, therefore, an insurance company is fair game whenever the opportunity is presented to hand out an economic shellacking. Let's look at the underwriting profit for a substantial number of years. During the 20 year period from 1931 to 1950 the underwriting profit on all lines written by member companies of the National Bureau of Casualty Underwriters averaged 7/10 of 1 per cent. What is more, that 7/10 of 1 per cent profit was before paying federal income taxes.

In a recent report of the American Hospital Association committee on insurance, which was mailed to every member hospital, the following statement was included: "The statistical report also indicates that claim expense, particularly for public liability and malpractice insurance, varies considerably by areas, as it is affected by state statutes and court decisions. As a whole, however, it can be stated from the figures which we have secured that insurance rates for hospitals are not entirely equitable on the basis of experience."

ARE RATES TOO HIGH?

Now when they say that insurance rates are not equitable, I am assuming they mean, based on the figures they use, that the rates the insurance companies are charging are too high and unfair. The figures in this report show: public liability, $2,675,105 premiums and $210,136 losses, for a loss ratio of 8 per cent; and malpractice, $1,786,015 premiums and $279,900 losses: a loss ratio of 16.6 per cent.

The figures published in the A.H.A. report are incorrect. Probably I should say that in truth they cannot very well be correct because I doubt whether the hospitals that are having the losses will report them to a committee, or whether a hospital could furnish the information as to what the expense involved might be, or the reserves set

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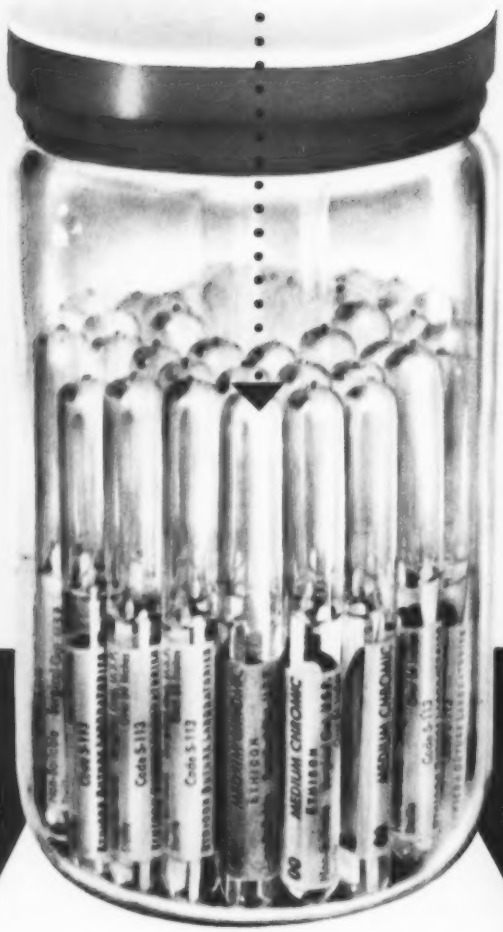

The "Tell-Tale Pink" Leak Detector unerringly points out a leaky tube by turning the white label or reel a bright "tell-tale pink." The new storage fluid, a component of this superior leak detector, is both colorless and nonstaining.

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There's a magic lip on this new pouring pitcher by Polar Ware. It won't drip — no matter what you pour, or from what angle you pour it. That means a glad good-bye to messy serving, an end to mopping up dribbles. And additionally, time gained in the faster filling of cups and glasses means time saved for other work.

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up by the insurance companies. I should like to present the actual figures over the same period of time, on approximately the same number of hospitals—hospitals which are members of the American Hospital Association, registered by the American Medical Association, and approved by the American College of Surgeons: Malpractice premiums, 1946 through 1950, $1,089,110.02; losses, $1,154,-565.76; loss ratio, 106 per cent. Public liability: premiums, $490,861.22; losses, $299,514.00; loss ratio, 61 per cent. The combined loss ratio is in excess of 85 per cent.

Now I do not wish to be misunderstood as to the objectives of the committee because I think the work that has been done is commendable in many respects, but it serves no useful purpose to put out misinformation.

STATE COVERAGE AFFORDED

There is a feeling abroad in the hospital field that the public liability risks of hospitals can be covered under specific malpractice policies and a general liability contract providing for injuries sustained as a result of the property as well as elevators, but these are not the only risks for which hospitals are subject to loss by reason of negligent acts, either in maintaining their properties or in the care and treatment of patients. Most policies of this nature, other than complete comprehensive coverage, specifically set forth in the insuring clause the coverage afforded and in order for the coverage to be provided, the injuries sustained must come under the provisions as set forth in those policies or the insurance is of no value.

Any information to the contrary is not well founded, and in this day and age there can be no question that hospitals should avail themselves of the broadest public liability policies obtainable, which provide coverage for all the operations of the corporation, whether the insurance is purchased in stock companies, mutuals or reciprocals. This is not an easy problem to solve, but neither is an effective program. However, for those who must deal not only with employes but with helpless patients, and the ever changing visitor problem, it is a task that must be accepted, and until such time as the hospitals themselves clean their own houses, eliminate hazards and educate their employes, no one is going to be able to solve the problem for them.

Traditionally, a hospital is a haven of mercy—a place where the sick are healed and the tortured are soothed. Yet pain and death are unavoidably present in any hospital. But pain and death through accidents as a result of negligence have no place there. Still, one of every three hospitals does not have properly flame-proofed hangings. One out of every three hospitals does not have good housekeeping, and four out of five hospitals do not store their flammables safely. Thirty per cent of all claims from hospital patients are due to treatment defects. The commonest of these are the treatments and errors in transfusion, anesthesia and dosage. Probably 10 per cent of the claims are from burns. The majority of these are from hot water bottles. Every hospital uses oxygen as a life-giving, life-saving gas, but all too often it becomes an instrument of death.

A grandmother visited a hospital and brought a birthday cake to a young polio victim in an oxygen tent. She lit one of the candles, and the tent caught fire. Two people died.

Another patient in an oxygen tent yearned for a cigaret. His young wife waited until the nurse left the room, and she lit a cigaret for him. One person died; two were horribly burned.

Falls resulting from unsafe floor conditions also come in for their share of the insurance costs.

Hospital people who pass judgment on insurance companies and publicly seek reductions in insurance rates should first ask themselves these questions: Do I maintain a safe institution and insist that the rules of safety be followed? Are the insurance companies subject to the same pressure of inflation as my business? Have the claims been morally and legally honest? Have I stood firmly for fair jury awards in injury cases and as firmly against excessive awards in such cases? Are insurance company costs and prices in line with my own, considering current conditions and not the conditions of 10 or 20 years ago? Have I opposed socialization of the insurance industry as forthrightly as I would oppose socialization of my own business, remembering that when socialism gets its foot in the door of one important branch of the free enterprise system, it would soon be in the door altogether?

When all our judges can honestly answer these questions affirmatively, we will have less to worry about with respect to the cost of insurance.

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Plymouth Perfect
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Top Management Has Its Troubles, Too

(*Continued From Page 72*)

tablished to provide opportunity for professional consultation with a doctor on medical care of the patient, as well as administrative contact with the administrator.

The department head, as an employe of the hospital, not a doctor, cannot obligate the hospital, or himself, by assuming responsibility for medical care. When the doctor is available, attuned to administrative considerations imposed on the department head, and cooperative, few troubles arise. But when the doctor is unavailable, or uncooperative, or disposed to work at cross purposes with the hospital administration, the department head is placed in an unenviable position. The department head then has no clearly defined or adequate recourse either to the medical or to the administrative staff.

DEPARTMENT HEADS CONFUSED

Where supervision of departments is shared by the administrator and the assistant administrator, confusion arises as to which departments are being supervised by which position, if at all. Under these circumstances, neither the administrator, nor the assistant administrator, nor the department head seems able to describe confidently the relationship of authority and responsibility that does exist. The department head may feel that he is free to elect whichever superior might be most favorably disposed toward him, and to change the election from time to time. This freedom of election might not suit the best interests of the hospital.

In addition, from the point of view of the department head, the job can be a lonely one and one calculated to increase any feelings of personal insecurity, when the department head either lacks guidance altogether or feels uncertain about whom he must please, uncertain about whom he may appeal to when orders and pressures from many sources conflict, and essentially uncertain in regard to his own status with management. Department heads, generally, look above their own office for guidance on major policy matters, and seek support in the knowledge that they may have access to the administrator or his designated deputy when guidance is needed.

Changes of hospital organization create another situation in which anxieties arise. A new position at the department head level may cause others of similar rank to take a defensive position lest their prerogatives be threatened. While many examples exist, a new position that might cause concern on the part of all department heads is that of personnel director.

This is not an argument against hiring personnel directors. It is an illustration of a position that might appear to overlap, even to compete with, the long established duties of line supervision that are sometimes jealously guarded. Orientation for people already employed, as well as for the new employe, is part of the issue, but, in the context of organization, people should know in advance about the organization changes that are to be made and the effect that these changes may have on their own positions. Advance notice can contribute to the bolstering of group morale during times of organization change. Hospitals communicate many items of importance to department heads and employes. Among these items, notice and adequate explanation of organization change should receive a high priority.

In this commentary, relatively little emphasis has been placed on what might be called "good organization" or "principles of organization" for hospitals. Even the most elaborate and most technical principles of organization serve only as rough guides and serve only as a basis for raising some of the questions that have been raised in this article.

In pursuing organization analysis, overemphasis on the mechanics and channels of formal organization may block or delay communication and coordination among hospital employes; people in the hospital will necessarily develop their own patterns of working relationships in order to get work done, and the formal organization may have to be modified to achieve maximum coordination of effort in the hospital.

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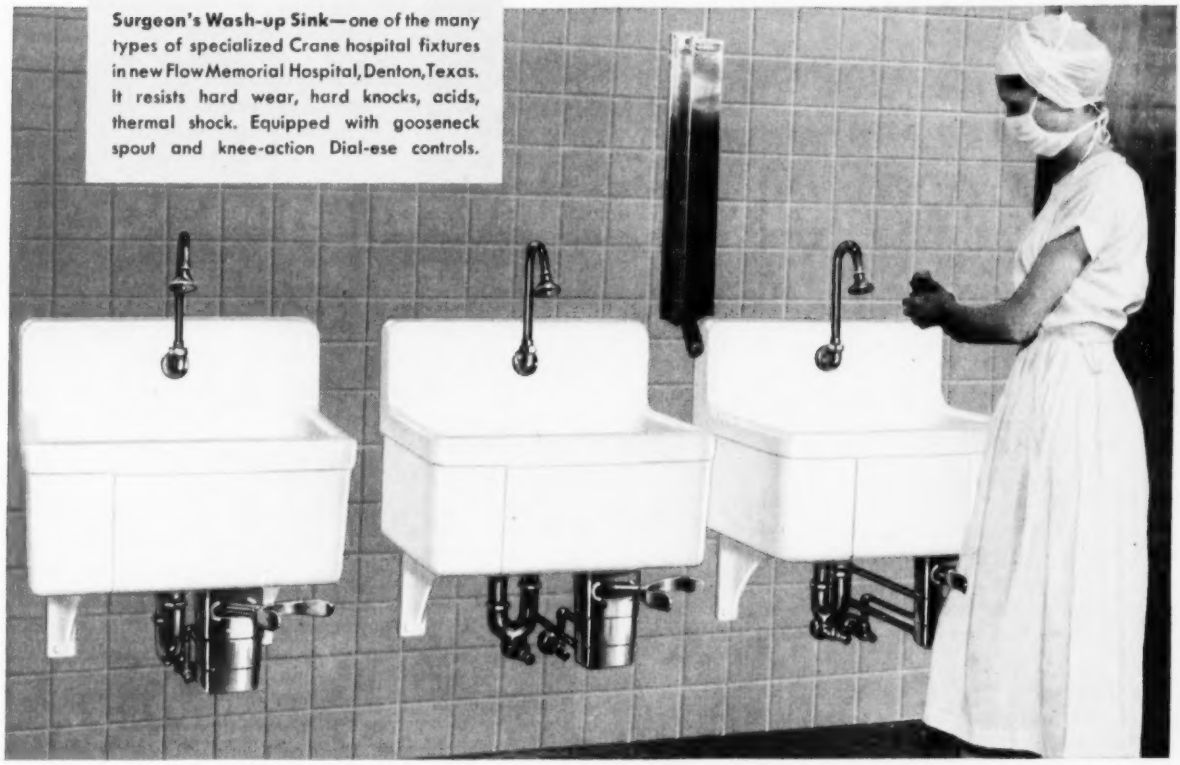

Surgeon's Wash-up Sink—one of the many types of specialized Crane hospital fixtures in new Flow Memorial Hospital, Denton, Texas. It resists hard wear, hard knocks, acids, thermal shock. Equipped with gooseneck spout and knee-action Dial-ese controls.

You're ahead three ways when your hospital plumbing fixtures are equipped with Crane Dial-ese controls.

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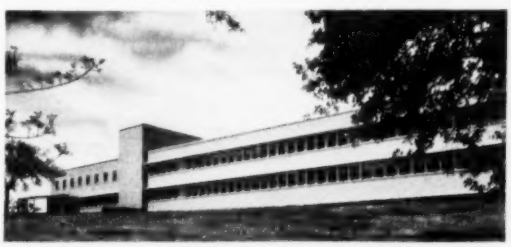
Dial-ese works on an entirely new principle, is one of the most important plumbing developments in years. Instead of closing *against* the flow of water, Dial-ese closes *with* it. Force of water actually aids in closing valve—continuous pressure helps hold it closed. No dripping! No needless waste to run up water bills and water heating costs.

Dial-ese resists corrosion and lime deposits, too—keeps working at top efficiency with minimum need for service. And when maintenance does become necessary, there's no need for lengthy shutdowns, no tedious repairs. Instead of removing and replacing individual parts, the maintenance man does the whole job with a simple interchangeable "cartridge." This one unit contains all working parts. Can be slipped out of the faucet and replaced in seconds.

Dial-ese is standard with all new Crane specialized hospital fixtures, or can be fitted to equipment you already have. Get full facts from your Crane Hospital Catalog—or from your Crane Branch, Crane Wholesaler or Plumbing Contractor.



Flow Memorial Hospital, Denton, Texas—designed by architect Bennett Crittenden, is Crane-equipped throughout. General contractor—Carpenter Bros., Dallas; Plumbing contractor—Baily Meissner, Wichita Falls.

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Osteopaths and the Hospital System

(*Continued From Page 54*)

men in as professors in the schools of osteopathy, the situation will correct itself in a few years, he indicated.

As it has turned out, however, the Judicial Council of the A.M.A., acting on a recommendation of Past President John W. Cline that the application of the principles of medical ethics to physicians' relationships with osteopaths be reviewed, declined to consider any change in the traditional A.M.A. position on the subject. "In the absence of a directive from the house of delegates," the council said in its latest official report, "and in the absence of any alternative statement from the osteopaths themselves that they no longer adhere to their original cult theories, the Judicial Council reasserts its opinion that all voluntary associations with osteopaths are unethical."

Since this report was rendered, the board of trustees of the A.M.A. has appointed a special committee for the study of relations between osteopathy and medicine. The committee has issued a questionnaire on osteopathy to secretaries of state and territorial medical societies and others, seeking information on licensure, practice, education, hospital affiliation and public relations of osteopaths. Among other opinions sought, the questionnaire asks whether over-all care of illness would be improved, lowered or remain the same "if doctors of medicine were to participate freely in undergraduate and postgraduate education of doctors of osteopathy," and "if ethical restrictions of voluntary associations with doctors of osteopathy were removed." It is hoped the answers may help determine what hospitals and their associations can do to resolve the situation which finds many hospitals today squeezed between legal and voluntary authorities.

Nobody questions the need for the highest type of medical standards in all hospitals and the constant desire to strive for that end, but some consideration must be given by professional associations to these hospitals now shackled by law. Unless it is faced by the national associations, this situation could easily become a threat to hospital standards everywhere.

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THE WATERLESS FOOD WARMER

are the imitations really as good?

Science recently produced an imitation diamond equal in all respects to the natural stone. Yet the diamond market remained undisturbed. Why? Because this achievement, while a scientific success was an economic flop. The imitation diamond cost many times more than the natural stone!

Repeated over and over again, this example is the history of imitations. In order to stay competitive in price, something must be left out, corners must be cut to reduce costs.

That's why it pays to investigate thoroughly when you are told that an imitation is *just as good as* Thurmaduke or *the same as* Thurmaduke.

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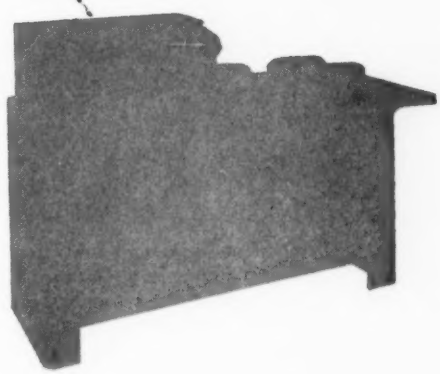

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NEWS DIGEST

Grace T. Crafts Receives Wisconsin Award . . . Arizona Elects Joseph Coppa . . . Utah Hospitals Exempt From State Labor Relations Law . . . Dr. Kogel Defends Fordham Against Race Bias Charges . . . Hueston Heads Chicago Council

Buzz Sessions Conclude One-Day Meeting of Wisconsin Hospital Association

MILWAUKEE.—More than four hundred administrators, department heads, trustees and members of women's auxiliaries attended the annual meeting of the Wisconsin Hospital Association here February 19. The need for more effective administration was the general theme of the meeting.

Prof. Gerald Clark, industrial engineering department, Wayne University, Detroit, opened the meeting with discussion of the "Application of Methods Engineering to Hospital Administration." "Methods engineering," Professor Clark said, "helps management use human and mechanical resources more efficiently. Administrative studies through methods engineering can often show how to make better use of present equipment and hence save the expense of buying new equipment." Professor Clark emphasized the fact that successful methods engineering requires close cooperation with hospital workers at all levels. He pointed out that hospitals regularly waste much of their intelligent professional personnel on jobs below their abilities.

MUST KNOW ALL COSTS

In discussing the administrators' responsibility in controlling costs, George Bugbee said that the administrator and the front office executives too often do not know enough about what every job in the hospital requires and what every worker is doing. He declared that complete knowledge is essential if we are to control pay-roll costs. Mr. Bugbee stressed the value of having every staff doctor understand the cost problem. He said that when doctors once understand the situation, it is much easier to get their help in reducing costs.

The methods engineering and job analysis work being done at Harper Hospital, Detroit, was discussed by Marion Wright, assistant administrator of the hospital. She urged that before

(*Continued on Page* 188)

Academy Drops 464 G.P.'s Who Neglected Graduate Studies

ST. LOUIS.—Failure to fulfill postgraduate study requirements cost 464 physicians their membership in the American Academy of General Practice, Mac F. Cahal, executive secretary of the academy, said at the annual meeting here last month. Current membership in the academy exceeds 16,000, it was reported.

The academy requires its members to complete 50 hours of postgraduate study a year, Dr. R. B. Robins, president, explained. "The great majority of members are more than keeping up with their postgraduate education," Dr. Robins said. "The entire purpose of the academy was to raise standards of general practice."

Explaining the academy's action in dropping 464 members last year, Dr. Murland Rigby, chairman of the membership and credentials commission, said practitioners "must study constantly to keep abreast of advancements in medical science." The family doctor, he added, is "required to know considerably more and must spend a greater amount of time keeping up his medical education than does the doctor who chooses to specialize."

Five thousand general practitioners attended the fifth annual scientific assembly here. The program was planned "to give the general practitioner an outstanding postgraduate course in diagnostic procedures, therapies and technics useful in everyday practice," Mr. Cahal said.

Arizona Association Picks Joseph Coppa for President

PHOENIX, ARIZ.—Joseph Coppa, superintendent of Mohave General Hospital, Kingman, was elected president of the Arizona Hospital Association at the association's ninth annual meeting here February 12 to 14.

The newly elected vice president is Dr. Francis J. Bean, superintendent of Pima County General Hospital, Tucson. G. M. Hanner, administrator of Good Samaritan Hospital, Phoenix, is the new secretary-treasurer.

Trustees appointed for three-year terms are Sister Mary Eucharia, superintendent of St. Joseph's Hospital, Phoenix, and Walter Montignani, superintendent of Yuma General Hospital, Yuma. Carroll Phelps, superintendent of St. Luke's Hospital, Phoenix, was appointed a trustee of the association, for a two-year term.

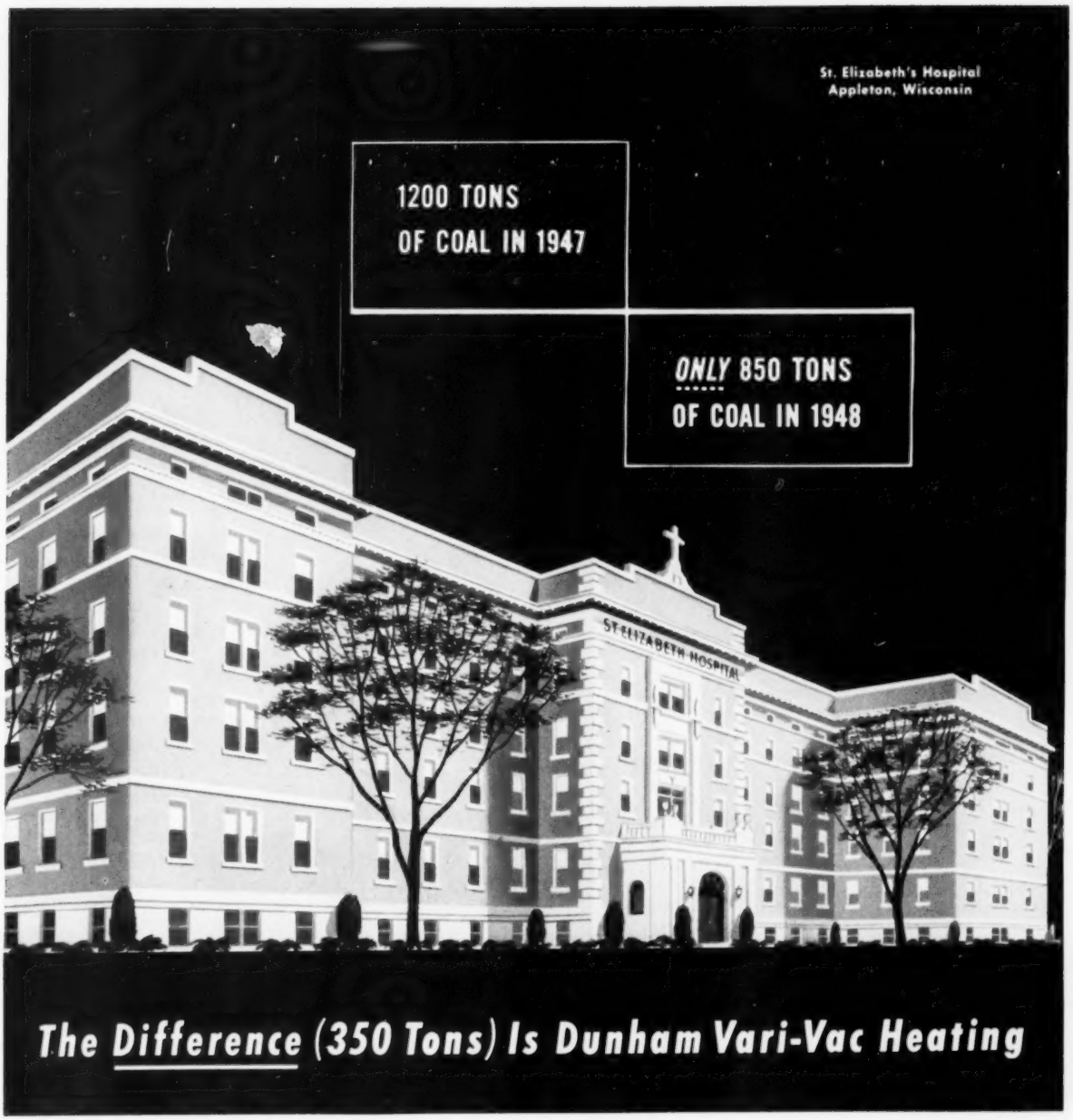
Two persons were chosen as delegates to the Association of Western Hospitals. They are Mr. Coppa, and Aubrey Thompson, superintendent of Williams Hospital, Williams.

CONDUCTS ONE-DAY WORKSHOP

The opening day of the convention was devoted entirely to a workshop conducted by Maurice Norby, deputy director of the American Hospital Association, and John H. Gorby, chairman of the community hospital section of the Association of Western Hospitals.

The annual banquet was held February 13, with Eugene C. Pulliam, president of Phoenix newspapers, as guest speaker.

Verdi Miller, San Francisco area dietetic representative of the Veterans Administration, gave the principal address at the session February 14. This was followed by an open question-and-answer period under the direction of Mr. Norby. The annual "fellowship luncheon" followed this session.



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NEWS...

Ralph M. Hueston Is Named New Head of the Chicago Hospital Council

CHICAGO.—Ralph M. Hueston, superintendent of Wesley Memorial Hospital, Chicago, since 1947, has succeeded Ray E. Brown as president of the Chicago Hospital Council. The council, which held its annual meeting here late in February, also named Leslie D. Reid as the new president-elect. Mr. Reid has been superintendent of Presbyterian Hospital since 1944.

Elmer E. Abrahamson, secretary of the board of Norwegian-American Hospital, was reelected to his third term as chairman of the board of directors. Wendell H. Carlson is the new vice president, and the Rev. Joseph A. George was reelected for a third term as secretary-treasurer. Mr. Carlson is administrator of Englewood Hospital, and the Rev. Mr. George is head of Evangelical Hospital.

Members elected to serve three-year terms on the board of directors were: E. I. Erickson, superintendent of Augustana Hospital; the Rev. Mr. George; Dr. Morris H. Kreeger, executive director of Michael Reese Hospital; Mr. Reid; Ernest C. Schmidt, president of Grant Hospital, and Franklyn B. Snyder, president of the board of managers of Presbyterian Hospital.

A featured speaker at the meeting was George K. Hendrix, chief of the bureau of hospitals of the Illinois Department of Public Health. Mr. Hendrix urged the council to launch a comprehensive study of hospital needs and resources in the Cook County area, even though the cooperation of many other health agencies would be needed. Mr. Hendrix said that his department had received a "tremendous number" of requests for advice on projected hospital construction from civic groups within the county. These requests were difficult to answer, he added, because there was little available information showing whether or not construction was needed. He explained that the Illinois Hospital Survey and Plan, completed in 1947, had not included Cook County because its problem was more complex and contrasted sharply with that faced by other areas in the state.

In discussing Mr. Hendrix's talk, Ray Brown suggested that the council representatives talk to the recently formed Chicago Area Fund to see if it would be interested in working with the council in forming a commission or committee to work out a long-term plan for hospitals in Chicago and Cook County.

In further discussion, George Hendrix pointed out that the Hill-Burton law should be modified to look at more than bed needs only. He felt that the Hill-Burton plan should study service needs, such as therapeutic x-ray, diagnostic laboratories, blood banks, outpatient departments, educational facilities, and administrative facilities, and that federal funds should be available to aid hospitals in improving their service ability.

Following the announcement by the Rev. Mr. George that the council had a 1952 surplus of $5658, council members approved a reduction in dues. The new rate is 5 mills per patient day of care rendered over the year, compared to the previous 6 mills, with the minimum again set at $200 a year and the maximum at $1000. At the same time, though, patient day statistics, upon which dues are based, were made current.

James R. Gersonde, executive director of the council, explained that the dues reduction was made possible not by any reduction in activity but by the larger share of total expenses assumed by the Illinois Hospital Association under the coordinated program of the two organizations. The I.H.A. approved a dues increase last year, which increased its total income by about $12,000 a year.

Mr. Gersonde, who gave his annual report, stressed the following four points which have been accomplishments of the council, working in cooperation with the I.H.A. during the last year: (1) A mutually agreeable contract has been worked out between hospitals and the Illinois Blue Cross plan; (2) the work of the committee on fire and safety has resulted in good working arrangements with the inspection bureau of the Chicago Fire Department and the adoption of a standard fire and safety inspection program; (3) an agreement has been

NEWS...

reached by Leslie Reid and his committee with the Chicago Welfare Department regarding payment for indigent patients on the basis of the full government reimbursable cost formula, and (4) the Chicago Hospital Council's plan to cooperate with commercial insurance carriers has worked successfully and has aided participating hospitals.

Georgia Board Members Hold First Conference

ATLANTA, GA.—A total of 74 persons, including 40 trustees representing 27 hospitals and 19 hospital administrators, attended the first annual conference of Hospital Governing Boards in Georgia here February 19.

Following registration, and greetings by R. C. Cropper, member of the Macon Hospital Commission, P. L. Bramblett, member of the Spalding County Hospital Authority, Griffin, assumed the duties of presiding officer.

The subject of the first morning session was "A Surplus Is Welcome But Hospitals Are Not Run for Profit." It was presented by Hampton McGibony of Minnie G. Boswell Memorial Hospital, Greensboro. The discussion leaders were M. M. Monroe of Ware County Hospital Authority, Waycross, and H. H. Hogg of Polk County Hospital Authority, Cedartown.

W. C. Harris of Winder-Barrow Hospital, Winder, presented the paper at the second morning session, the subject being "What the Hospital Authority Expects From the Hospital Administrator." Discussion at this session was led by Judge B. B. Heery of Warren A. Candler Hospital, Savannah, and Dr. E. M. Townsend of Tri-County Hospital Authority, Fort Oglethorpe.

Presiding at the afternoon sessions was Reuben Clark of Chatham County Hospital Authority, Savannah. The subject of the first afternoon session was "Hospital Insurance: What Can Hospital Authorities Do to Improve the Hospital Insurance Situation in Georgia." Gene Kidd, past president of the Georgia Hospital Association and administrator of Phoebe Putney Memorial Hospital, Albany, talked on the subject. The discussion which followed was led by T. L. Blalock of the Georgia Mutual Hospitalization Service, Waycross; Samuel Butler of the

NEWS...

Georgia Hospital Services Corp., Inc., Columbus, and C. J. Anderson of the United Hospital Service Association, Atlanta.

The paper that Dr. R. C. Williams of the Division of Hospital Service, Georgia Department of Public Health, gave at the closing session was on "Organizational and Operational Experiences of New Hospitals—A Study of the First Two Years' Operating Experience of Ten New Hospitals in Georgia."

Kogel Defends Fordham on Admission Policies and Charges of Race Bias

NEW YORK CITY.—Following a recent investigation into allegations of improper denial of admission of four infants and an adult to Fordham Hospital here, Dr. Marcus D. Kogel, commissioner of hospitals, gave the hospital a clean bill of health.

Rejecting as "slanderous" a charge by the Bronx River Houses Tenants Council of race discrimination, he said he denied it "with the same revulsion that one must deny disloyalty, homosexuality or any other vice currently enjoying public disfavor."

Welcoming the interest in the accusation shown by the National Association for the Advancement of Colored People, he said he had asked it to establish a panel of qualified physicians to investigate. Walter White, executive secretary of the association, said it would select such a panel and would withhold judgment until its report was received.

A conference had previously been held with representatives of the Bronx units of the association, the American Jewish Congress, the Urban League, the Anti-Defamation League, and the Morrisania Presbyterian Church, to hear the views of the infants' relatives. They were divided on whether there was evidence of discrimination, the association reported

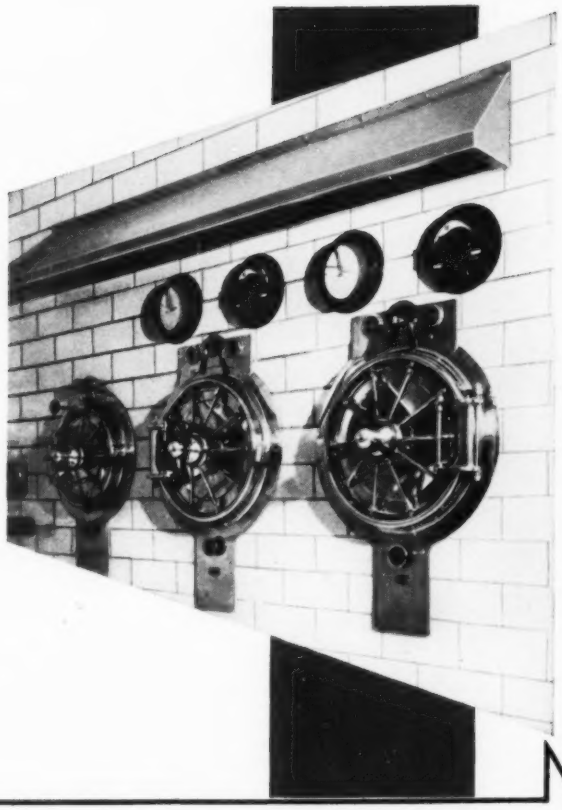
Dr. Kogel, who had studied the records of the cases and interviewed the hospital staff, said the decisions of the physicians against admitting the patients who later died were "in each case reasonable." He stated:

"The coincidence arising from the fact that two of the infants who were not admitted on one day subsequently were admitted and died the following day is nothing more than a tragic caprice of the law of averages. It has no other significance. So long as medicine remains an imperfect science failure to admit people in whom rapid change for the worse is unforeseeable will remain an unhappy and distasteful reality."

Concerning the charges brought by the tenants' group, Dr. Kogel said:

"To put it charitably, I do not regard the Tenants Council as competent to pass judgment on medical decisions. The fact that it does so with such ease and then proceeds with equal ease to vilify Fordham Hospital is in itself a measure of the organization's integrity and character."

The department released a report from the hospital showing that Ralph Hosmer, a 13 month old child had no temperature but was found to be suffering from tracheal laryngitis when brought to the emergency room on November 21. Penicillin and other medicines were administered. He was brought back the next day and found to be suffering from bronchial pneumonia, of which he died four hours



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later. He was a retarded microcephalic child, the report said.

Michael Ballard, a six month old baby, was brought to the hospital at 11 p.m. December 4. His temperature was 100.8 degrees; after penicillin was administered the parents were told to bring him back the next day. He was brought in at 7:30 a.m. with a temperature of 106 degrees and died of bronchial pneumonia 12 hours later, in spite of blood tranfusions, terramycin and penicillin.

Two other infants, given emergency treatment February 13, and taken home by their families, died the next day at the hospital. The Ballard baby, like the two children who died February 14, was a Negro. The Hosmer baby was not.

The adult involved was a 29 year old woman who was examined in the emergency room on December 30. She was admitted to the hospital the following day and died there January 6.

National Health Needs Considered by Council

NEW YORK CITY.—The two-day forum on "Advancing the Nation's Health," which highlighted the National Health Council's 33d annual meeting here March 18 to 20, had 27 leaders in various health fields participating in the program.

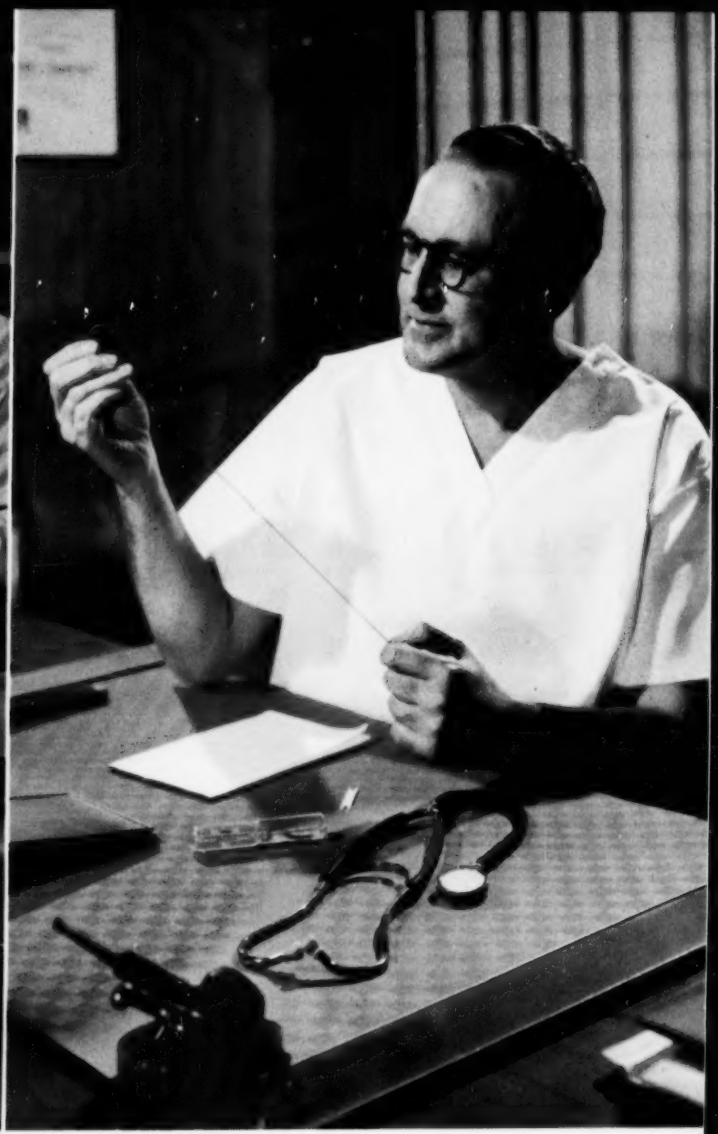
State and local health council leaders, representatives of member national organizations, and representatives of civic, business, farm, labor and other groups attended.

In stating the purpose of the meeting, Dr. Thomas D. Dublin, executive director of the council, said: "Health progress of the past half-century in the United States has been spectacular. Yet weaknesses exist. Many of them are due to the very complexity of the network of professional groups, educational facilities, business interests, varied social and economic forces, and individual effort that together determine the health status of any one area and of the nation as a whole.

"The National Health Council, an association of 42 national groups, including the major voluntary organizations and professional societies in the health field, believes that the time has come when a deliberate, periodic effort should be made to appraise the entire health network. The board of directors therefore determined to begin such an appraisal at a forum to feature the council's 33d annual meeting."

Mrs. Oswald B. Lord, council president and United States representative to the United Nations Commission on Human Rights, presided over the opening general session, which was a report of the President's Commission on the Health Needs of the Nation. The session took the form of a panel discussion among the leaders from varied fields who served on it. Dr. Paul B. Magnuson, its chairman, and Chester I. Barnard, its vice chairman and chairman of the National Science Foundation, outlined the commission's purposes, policies, findings and recommendations.

During two afternoons and one morning, forum participants divided into five groups to discuss such subjects as: "Meeting the Needs for Health Personnel," "Building Better Health Facilities," "Organizing Health Services More Effectively," "Paying the Bill for Personal Health Services," and



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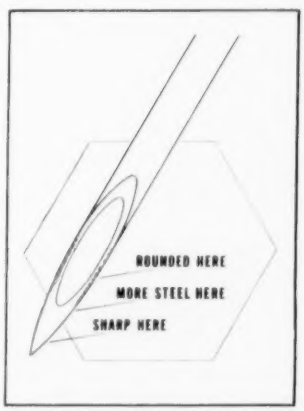

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NEWS . . .

"Fostering Research for Better Health."

Featured speaker at a dinner to close the forum program was Dr. Alan Gregg, vice president of the Rockefeller Foundation.

Utah Hospitals Free of Labor Relations Board

PROVO, UTAH. — Exemption from jurisdiction of the State Labor Relations Law was obtained for nonprofit hospitals in Utah last month when the legislature passed a bill sponsored by hospital administrators and trustees, John Zenger, administrator of the Utah Valley Hospital here, reported last month.

The new law does not prevent unionization of hospital employes specifically, Mr. Zenger pointed out, but it does free hospitals from the necessity for negotiating with unions under the mandatory negotiation clause in the State Labor Relations Act.

Church and community sponsored hospitals carried on an active campaign for enactment of the amendment, Mr. Zenger reported for the state hospital association.

"Two years ago, employes of the Utah Valley Hospital were unionized," Mr. Zenger explained. "The hospital utilized all legal means to resist this movement, because of the belief of its board of directors that it is against public policy and the interest of patients to have unionization of hospital employes.

"Hearings were held by the state industrial commission and the Utah State Supreme Court, objecting to the inclusion of hospitals under the State Labor Relations Act."

The hospital lost on this plea, it was explained, following which an effort was made to invoke the provisions of the Taft-Hartley Act, exempting nonprofit hospitals, in the federal district and federal circuit courts. Again, the hospital lost.

Then, Mr. Zenger related, the hospitals of the state decided on active sponsorship of an amendment to the labor relations law. "Through the united efforts of all church and community hospitals and active work by many members of the boards of trustees and other interested citizens, our bill was passed and signed by the governor last month," he said.

NEWS...

Duke University Revises Nursing Course

DURHAM, N.C.—To help meet the nursing shortage in North Carolina, Duke University's school of nursing will begin a new training program this summer that is expected to more than double the student body in three years, Dr. Hollis Edens, university president, announced recently.

"This program will not only help meet the need for bedside nurses in North Carolina," Florence K. Wilson, dean of the nursing school, declared, "but it also will help fill the demand for head nurses, administrators and supervisors."

The university previously has required one year of college for admission to its school of nursing. Under the new program, high school graduates will be eligible to enter directly into a revised three-year course leading to the diploma in nursing, or into a new four-year program leading to the degree of bachelor of science in nursing. The latter program will integrate general and professional education by requiring the regular undergraduate studies along with a broad foundation for teaching and admission as well as experience in public health nursing.

It was further pointed out that graduates of the three-year diploma course may take additional academic work leading to a B.S. degree in nursing while they are in practice.

Madison Park Hospital Acquired by Adelphi

BROOKLYN, N. Y.—The Madison Park Hospital here has been acquired by Adelphi College of Garden City, N. Y., which will operate it in connection with the college's training program for nurses and other auxiliary medical service personnel.

By acquiring the private hospital, which has 163 beds and 37 bassinets, Adelphi will be able to broaden its community service program through the extension of its mental health center for children and youth to Brooklyn.

The management of the hospital will continue under Dr. Albert R. Fritz, Dr. J. Dudley Fritz, and their sister, Mrs. Pauline Fritz Ammend, who become members of the Adelphi College administrative staff.

NEWS...

Bell Made From Chains, Manacles to Open Drive

NEW YORK CITY.—Handcuffs, chains and manacles no longer used to restrain mental patients have been sought in letters sent out recently by the National Association for Mental Health, Inc., to 220 state mental hospitals.

When enough metal is collected, the association announced recently, it will be used to cast a bell which will be rung at a public ceremony to start Mental Health Week, May 3 to May 9.

The ringing of the bell will start the first nationwide fund raising drive of the association, Robert M. Heininger, the association's executive director stated. Cooperating in the drive to establish a Mental Health Fund will be 250 state and local mental health organizations.

The fund will be used "to advance research on mental and emotional illness, promote the improvement of conditions in mental hospitals, assist in the creation of mental health clinics, and carry on mental health education through films, dramatic sketches, literature, forums and lectures," Mr. Heininger said.

Bellevue Expects Loss of Nurses to V.A. Hospital

NEW YORK.—Completion next year of a 1200 bed Veterans Administration hospital at 22d Street and the East River may aggrevate the nursing shortage at the city's near-by Bellevue Hospital, Dr. Marcus D. Kogel, New York hospital commissioner, declared last month. V.A. nurses make $1000 a year more than the city can pay, Dr. Kogel noted. Some wards might be forced to close as a result of the personnel shortage, he added.

The Veterans Administration outbids other hospitals for the services of professional and technical personnel, Dr. Kogel explained. "Our nurses would have to be more than human not to take the extra $1000 a year offered by the Veterans Administration," he said. "It looks as though we were replacing the ancient facilities at Bellevue in order to train nurses for the V.A.," he stated, commenting on a projected $14,000,000 program for expanding and improving the department's school of nursing.

"It looks to me as though we need federal and state subsidies for schools of nursing," Dr. Kogel concluded.

Expressing doubt that other hospitals had suffered loss of personnel to V.A. institutions, Brig. Gen. Ralph G. De Voe, manager of the Veterans Administration hospital in the Bronx, pointed out that the city would have to assume responsibility for patients now cared for in V.A. hospitals if the V.A. system did not exist. However, Gen. De Voe agreed that government services might be criticized for taking nurses trained by other agencies. This was not the case during World War II, he noted, when the federal government subsidized nursing education through the Cadet Nurse Corps program.

"I'm sorry they stopped it after the war," he said. "The solution is to make the nursing career more attractive. At present a girl just out of high school can get about the same pay in an office job as she would after spending three more years studying nursing."

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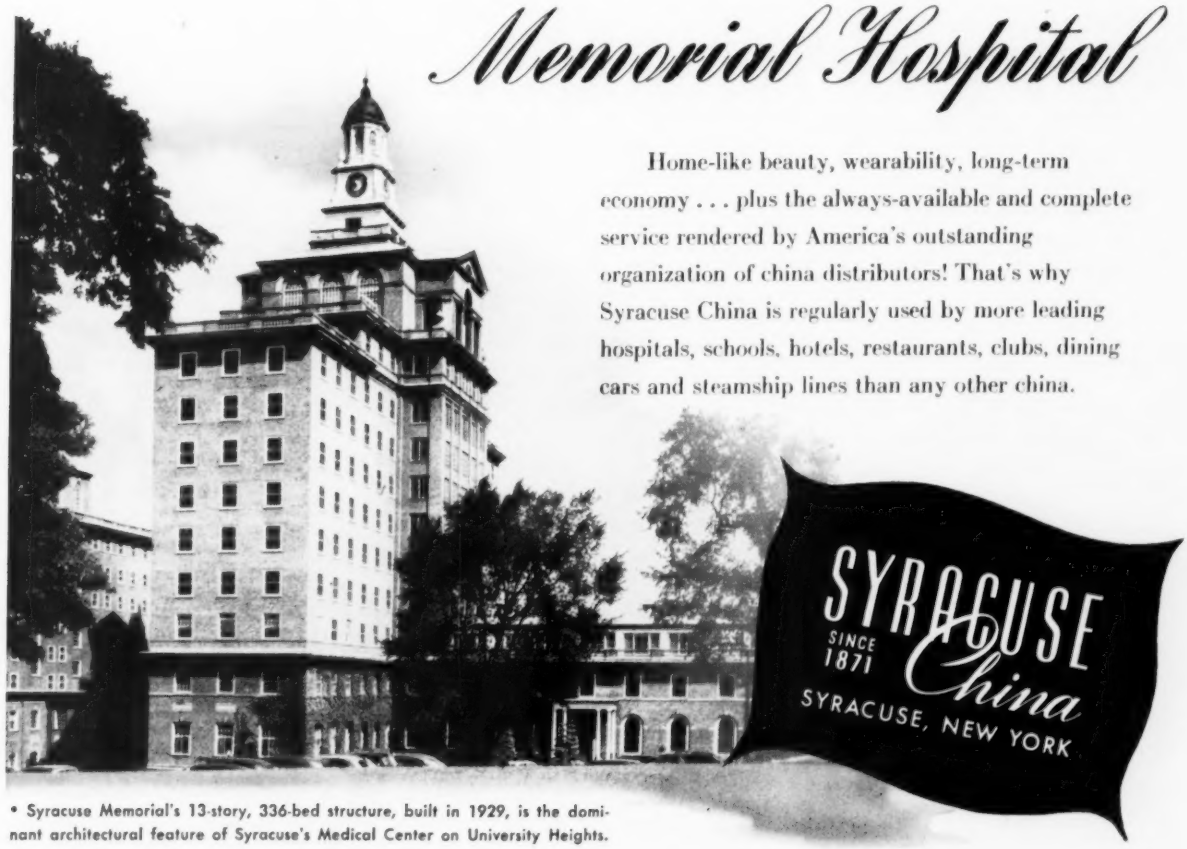

• Syracuse Memorial's 13-story, 336-bed structure, built in 1929, is the dominant architectural feature of Syracuse's Medical Center on University Heights.

NEWS...

Tri-State Assembly May Attract 7500 Delegates

CHICAGO.—More than 7500 persons are expected to attend the 23d annual Tri-State Hospital Assembly, which will meet here May 4, 5 and 6 at the Palmer House.

"Expanding Hospital Horizons" is the theme of the assembly, which is sponsored by the hospital associations of Illinois, Indiana, Wisconsin and Michigan, under the chairmanship of Dr. Malcolm T. MacEachern, director of professional relations of the American Hospital Association.

Dr. Edwin L. Crosby, president of the A.H.A., will give the opening address at the morning general session May 4, when he will discuss "Accreditation of Hospitals by the Joint Commission—Plan of Operation, Survey Procedure, Follow-Up, Evaluation and Rating." The same evening the 34 sections of the assembly will unite in a forum on the theme, "Obtaining Efficiency in Each Department of the Hospital." The Tuesday morning general session will be devoted to a discussion of recruitment and education of nurses.

Among the speakers at the morning sessions, besides Dr. Crosby, will be Dr. Arthur C. Bachmeyer and Harry Becker, director and associate director, respectively, of the Commission on Financing of Hospital Care; Maurice Norby, assistant director of the A.H.A.; Dr. Elmore Petersen, dean of the school of business at the University of Colorado; Dr. Robin C. Buerki, executive director of the Henry Ford Hospital, Detroit; Helen Nahm and Marion Sheahan of the National League of Nursing, New York City, and Franklin Carr, administrator of Waukesha Memorial Hospital, Waukesha, Wis.

Recruitment to Be Stressed During Hospital Week

CHICAGO.—Emphasis will be placed on recruitment of volunteers and auxiliary members, as well as on the traditional objective of stimulating community interest in hospitals, during the 1953 observance of National Hospital Week, which begins May 10, it was announced recently.

Women's auxiliaries that are members of the American Hospital Association have offered to help their hospitals conduct a full week's program.

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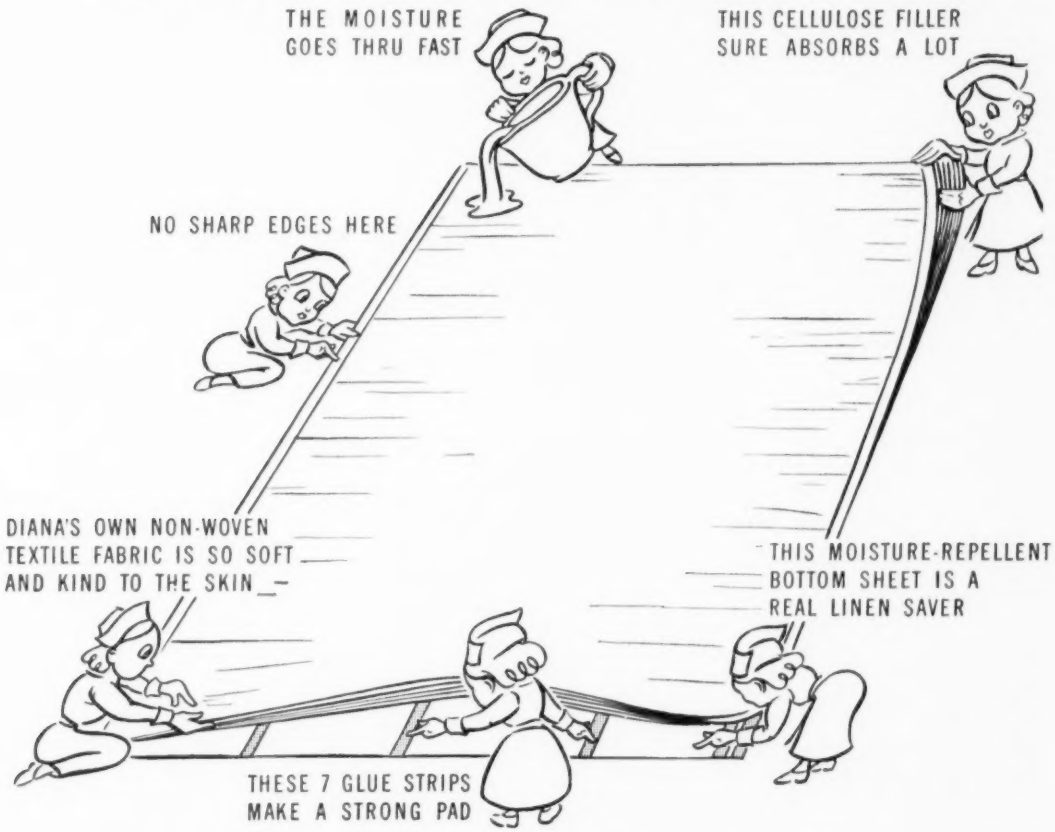

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NEWS...

Department of Health, Education and Welfare

(*Continued From Page 73*)

not disturbed. The exception is that the new Commissioner of Social Security is to be a presidential appointment; under F.S.A. this was a career post protected by civil service and with the commissioner appointed by the F.S.A. administrator.

In place of the abolished F.S.A. "holding company," the usual department structure is erected. At the top is the Office of the Secretary. Included in this are five positions: Secretary, Under Secretary (deputy), two Assistants to the Secretary and the officer referred to, the Special Assistant to the Secretary for Health and Medical Affairs.

Except that by law the under secretary is acting secretary in the absence or disability of the secretary, the secretary has complete authority to designate the duties of the under secretary as well as her two assistants. But the reorganization plan itself sets qualifications for the special assistant for health, and also sets forth some of his official duties. Like the secretary, and the two assistant secretaries, the special assistant for health would be appointed by the President, subject to Senate confirmation.

Under the Office of the Secretary there is just one thin layer of offices, carrying out the usual departmental arrangement for getting work done after decisions have been made. This consists of the two assistant secretaries, one for operations and the other for planning and surveys, and an office of administration. Directly under this line of offices are spread out the components, each of equal rank: Public Health Service, with its various hospital activities; the Office of Education, Social Security Administration, the Department's Field Service with its regional directors, the Office of Vocational Rehabilitation, and the Food and Drug Administration.

Thus, the Division of Hospital Facilities (Hill-Burton) moves undisturbed into the new department, along with all other functions of Public Health Service.

OFFICE IS UNIQUE

The office of Special Assistant to the Secretary for Health and Medical Affairs — unique in government — is the key to the new importance attached to such things as Public Health Service, state health grants, and Hill-Burton operations.

Under an administration interested in properly emphasizing medical matters, this special assistant could be the most powerful figure in government medicine, whose views, expressed through the secretary at cabinet meetings, would carry influence throughout every government operation. Mrs. Oveta Culp Hobby has indicated this will be the case as long as she is in office.

Even with an unsympathetic administration, the special assistant would have certain specific, important duties. The reorganization plan, which is the law in this case, says of this special assistant:

"There shall be in the Department a Special Assistant to the Secretary (Health and Medical Affairs) who shall be appointed by the President by and with the advice and consent of the Senate from among persons who

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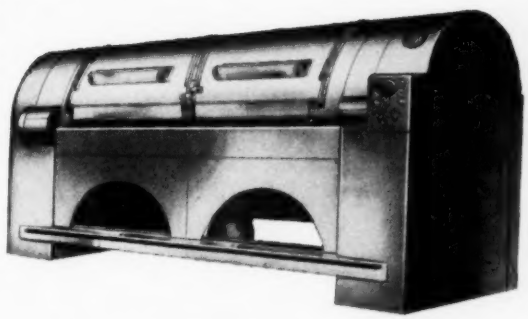

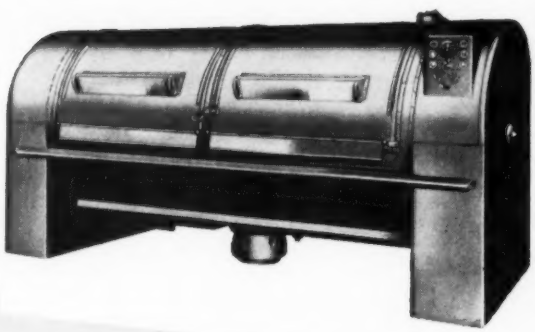

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are recognized leaders in the medical field with wide nongovernmental experience; he shall review the health and medical programs of the Department and advise the Secretary with respect to the improvement of such programs and with respect to necessary legislation in the health and medical fields, and shall receive compensation at the rate now or hereafter provided by law for assistant secretaries of executive departments."

It is significant that specific responsibilities are stated for no other top official of the new department; even the two assistant secretaries, presidential appointees, are not given this distinction. The plan merely states that they "shall perform such functions as the new Secretary may prescribe."

It should be noted that although the special assistant would have to be a "recognized leader in the medical field" he would not have to be a physician. Presumably, if some future president decided that a hospital administrator had the ability and qualifications for the job, he could be appointed. Also, the wording specifically rules out appointment of a Public Health Service, Veterans Administration, or military doctor, because of the requirement for "wide nongovernment experience."

INTERPRETATION OF DUTIES

An interpretation of the special assistant's duties, as laid down in the plan, indicates that the special assistant, if fully supported by the secretary, will have vast responsibilities. He will:

1. Review the health and medical programs of the department, advising the secretary as to whether they should be amended, expanded or reduced. This would apply to regulations issued under the Hill-Burton program, among other things. It could not, however, affect the basic H.B. law, which would have to be changed by Congress. Under this authority he would also hold a checkrein on federal employe health programs conducted by P.H.S. in other government agencies, as well as the new department.

2. "Advise the Secretary with respect to new legislation." This could, under the proper circumstances, be a significant function. Not only would he be able to guide and mold new legislation proposed by the department itself, but he would also have a firm hand in shaping the department's policy on legislative proposals originating outside the department. His views certainly would be important, for example, in determining how much money should be requested for the Hill-Burton program, and in deciding whether the department should press the Oscar Ewing plan for free hospitalization of old-age and survivors insurance beneficiaries. These duties are stated in the law; they would have to be performed regardless of the administration in power. At the time Reorganization Plan No. 1 was presented to Congress, Mrs. Hobby's office issued a job description, further explaining the work of the special assistant. It reaffirmed the legally specified duties discussed here, and added the following:

1. He will be the "chief staff policy adviser" to the Secretary on health matters and will represent the Secretary on top level intergovernmental

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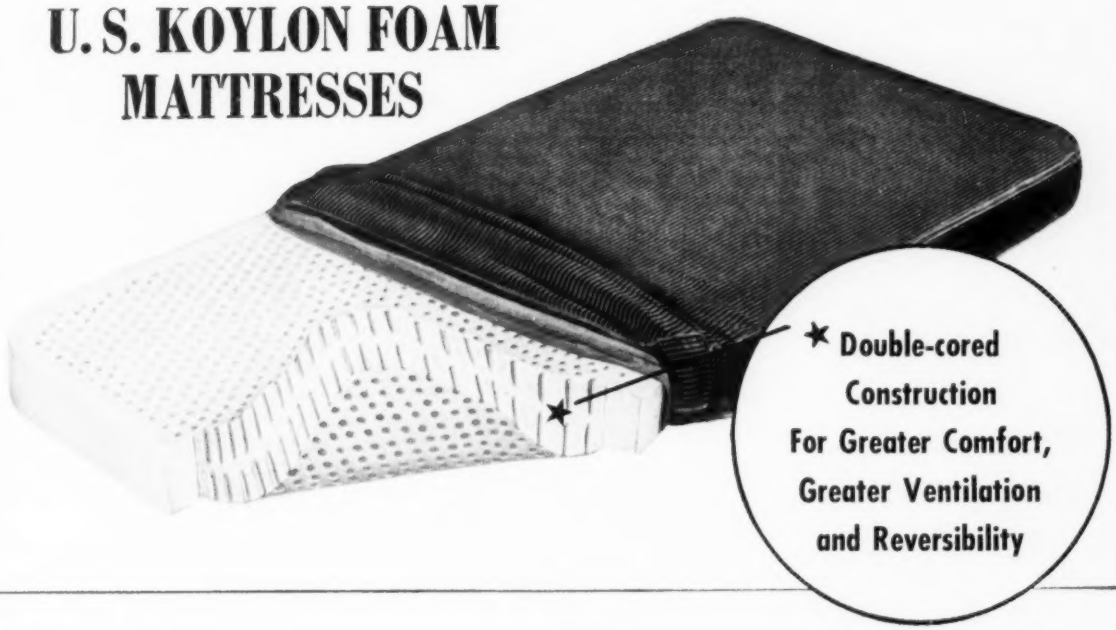

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committees, such as the Health Resources Advisory (Rusk) Committee of the Office of Defense Mobilization.

2. He will be liaison officer for the Secretary with important nongovernmental groups, "such as American Medical Association, American Dental Association, American Hospital Association, American Public Health Association, and the Association of State and Territorial Health Officers."

3. He will also be the personal representative of the Secretary in dealings with World Health Organization and other international groups. (However, neither in the domestic nor international field will he supplant the usual representation from such departmental units as Public Health Service.)

4. At the direction of the Secretary, the special assistant will see that proper coordination is established and maintained on health matters among the department's various constituents, such as Public Health Service, the Children's Bureau, and Food and Drug Administration. The job description adds that such coordination "is a matter of substantial importance."

The special assistant obviously will have direct access to the Secretary. This relationship is evident on the organizational chart, but Mrs. Hobby has given additional assurance that nothing will be done to interfere with this arrangement, such as a regulation requiring him to report to the under secretary of the department.

This special assistant could, if the Secretary so desired, be authorized to exercise all of her functions in health matters. The Secretary is given this unusual authority to delegate full powers in the section of the plan which states:

"Performance of functions of the Secretary—The Secretary may from time to time make such provision as the Secretary deems appropriate authorizing the performance of any of the functions of the Secretary by any agency or employe of the Department."

Thus this official, acting for the Secretary, could not merely advise but actually could reach down into any health or medical program and require that his or the Secretary's policies be carried out.

At hearings on the reorganization plan, Mrs. Hobby assured the house and senate committee on government operations that it would promote efficiency and economy. At the hearings, Sen. McCarthy (R., Wis.) criticized the proposed reorganization for not going far enough. "Under this plan Mrs. Hobby does not have the power of a good housecleaning," he said.

Democrat members of the two committees objected to appointment of the special assistant secretary on health problems, claiming it was a "sop" to the American Medical Association aimed at obtaining A.M.A. support.

Former President Hoover, whose commission on government operations two years ago had proposed consolidation of all federal medical services, including the Veterans Administration and medical establishments of the armed services in the U. S., endorsed the reorganization plan, in a telegram to the committees, as a constructive step. He also suggested an "exhaustive investigation of the federal hospital and medical setup, with a view to elimination of waste."

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NEWS...

British Health Plan Popular in This Town

LONDON, ENGLAND.—Most residents in a small community near Liverpool are overwhelmingly in favor of the National Health Service, after four years of it, according to a recent survey made by Daniel Reid Ross, former research director of a housing survey in Chicago.

The survey, which took in 5 per cent of the community's 12,474 residents, was published in the February issue of *Medical World*, journal of British general practitioners.

The survey disclosed that, with possibly one or two minor alterations, "most people," or 81 out of 86, were prepared to accept the health program as a basis for distributing the available medical services to the community.

Other facts disclosed by the survey include: Only 2 per cent of those surveyed felt that medical attention had deteriorated since the state service began; 38 per cent had not used any of the free facilities and services offered; 7 per cent of the families used the services of district nurses, and 21 per cent had treated themselves for illness when they could have had free medical attention.

Long Distances Traveled for Saskatchewan Institutes

REGINA, SASK.—Two hospital institutes were held during the last two weeks of February in the province of Saskatchewan, Canada, which were attended by representatives from most of the 145 general hospitals of the province.

Although more than 100 of the hospitals in the province have rated capacities of fewer than 25 beds, hospitals, both large and small, were well represented. The total registration was 293, of which 112 were administrators and accountants, 96 were superintendents of nursing, and 85 were trustees.

The first institute was held in Regina, the capital city of the province, and the second in Saskatoon, the university center. Each institute program covered similar topics, and while there were some general sessions, most of the time was devoted to workshop discussions.

Because standardized hospital accounting and statistical reporting is being obtained through Canada through the introduction of a new hospital accounting manual, the hospital accountants and administrators reviewed the procedures and practiced preparing hospital accounting records using the standardized forms.

In their workshop sessions, the superintendents of nursing discussed technics and procedures. They also discussed dietary service and diet therapy, hospitals and public health nursing, ward management, duties of nurses and nurse's aides, and the rôle of the combined laboratory and x-ray technician.

The trustees reviewed the principles of organization, fire prevention, and housekeeping. They also discussed labor legislation, orientation of new board members, insurance, relationships with medical staffs, and similar topics.

Although the government of Canada provided financial assistance to sponsor the institutes, the provincial government organized and supervised the programs.

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NEWS...

Calls for Speedy Changes in Medical Curriculum

CHICAGO.—The entire medical curriculum must be restructured by medical educators to meet the changing health needs of today, Dr. George Packer Berry, dean of the Harvard University Medical School and a member of the board of directors of the Commonwealth Fund, stated recently.

Dr. Berry, writing in the March issue of the *Journal of Medical Education*, named freedom of opportunity for good health as a basic human right. He declared: "That this opportunity for good health should be provided for all is an insistent and growing demand."

The movement, he said, must come from the medical profession itself and properly starts with the education of future doctors. Dr. Berry continued: "Let us not forget that if we do not do some very hard thinking and acting right now, someone whom we believe to be less competent than we will do the acting for us without thinking. If we believe that we are the best architects, it is up to us to produce the plans."

In describing a six-year program of teaching institutes to be sponsored by the Association of American Medical Colleges, Dr. Berry said the purpose of the institutes will be to examine the medical curriculum critically to determine what changes need to be made to bring it up to date.

Careers Committee Reports Increase in Enrollments

NEW YORK.—During the last year, 42,103 new student nurses were admitted to schools of professional nursing in the United States, Theresa I. Lynch, chairman of the Committee on Careers in Nursing, National League for Nursing, announced recently.

The committee conducts the national student nurse recruitment program.

Miss Lynch also stated that an additional 439 students entered nursing schools in Hawaii and Puerto Rico. This brings the total number of new student nurses in the United States and its territories to 42,542 in 1952, compared to a total of 42,053 in 1951.

The increase in number is encouraging, Miss Lynch said, because it

NEWS...

marks the beginning of a gradual rise in nursing school admissions which may be expected over the next few years as population in the 17-18 year old age bracket increases. However, because of the low birth rate of the depression years, she said, a sharp upswing in nursing school admissions cannot be anticipated until 1958 when the babies of World War II will be graduating from high school, and then only if the factors affecting recruitment remain stable.

Clinton Nurses Back After Wholesale Resignations

CLINTON, ILL.—Virtually the entire staff of registered and practical nurses at the 45 bed John Warner Hospital here resigned last month in a dispute between Bruce Barton, hospital administrator, and Mrs. Mary Groves, nursing supervisor and formerly hospital superintendent, over management of the nursing service.

After a three-day lapse, the nurses returned to duty, it was reported. Mrs. Groves was dismissed by the hospital board of directors, whose action supported the administrator.

During the walk-out, service to patients was maintained by importing nurses from hospitals in near-by cities, Mayor H. E. Breighner of Clinton said.

The dispute developed when Mr. Barton, who was employed by the board last January, instituted new procedures in the nursing department to effect necessary economies, it was explained.

Don E. Francke Gets Whitney Award

DETROIT.—Don E. Francke, chief pharmacist at University Hospital, Ann Arbor, Mich., and editor of the *Bulletin of the American Society of Hospital Pharmacists*, was named recipient of the 1953 H.A.K. Whitney Lecture Award presented by the Michigan Society of Hospital Pharmacists. The award is presented annually to an individual making significant contributions to the progress of hospital pharmacy, the society explained. Presentation of the award to Mr. Francke will be made at a testimonial dinner here on May 7, it was announced.

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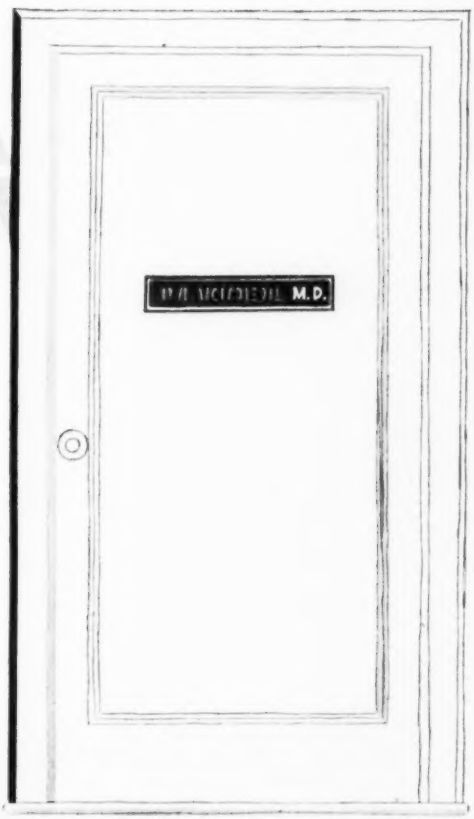

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COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Palace Hotel, San Francisco, Oct. 5-9.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, San Francisco, Aug. 31—Sept. 3.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Los Angeles, Oct. 18-21.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION MEDICAL RECORDS LIBRARIANS' TRAINING SCHOOL, Detroit Osteopathic Hospital, Detroit, May 18-22.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Baker Hotel, Dallas, Tex., June 15-19.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, Royal York Hotel, Toronto, Ont., June 28-July 2.

ASSOCIATION OF WESTERN HOSPITALS, Hotel Utah, Salt Lake City, April 27-30.

BLUE CROSS AND BLUE SHIELD PLANS, Hollywood Beach Hotel, Hollywood, Fla., April 12-15.

CANADIAN HOSPITAL COUNCIL, Chateau Laurier, Ottawa, May 18-20.

CATHOLIC HOSPITAL ASSOCIATION, Kansas City, Mo., May 25-28.

COLORADO HOSPITAL ASSOCIATION, Antlers Hotel, Colorado Springs, Nov. 19, 20.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 3, 4.

INSTITUTE ON ANESTHESIA, Somerset Hotel, Boston, June 22-26.

INSTITUTE ON CENTRAL STERILE SUPPLY, Claridge Hotel, Atlantic City, N.J., May 18, 19.

INSTITUTE ON DIETARY DEPARTMENT ADMINISTRATION, Park Sheraton Hotel, New York City, Oct. 26-30.

INSTITUTE ON FRONT OFFICE PROCEDURES, President Hotel, Kansas City, Mo., April 13, 14.

INSTITUTE ON HOSPITAL ENGINEERING, Wardman-Park Hotel, Washington, D.C., March 30-April 3.

INSTITUTE ON HOSPITAL LAUNDRY MANAGEMENT, Radisson Hotel, Minneapolis, May 11, 12.

INSTITUTE ON HOSPITAL PHARMACY, Loyola University, Los Angeles, June 15-19.

INSTITUTE ON HOUSEKEEPING, Somerset Hotel, Boston, Nov. 16-20.

INSTITUTE ON LAUNDRY, Park Sheraton Hotel, New York City, Nov. 9-13.

INSTITUTE ON MEDICAL RECORDS ADMINISTRATION, Yale University, New Haven, Conn., March 29-April 2.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, St. Charles Hotel, New Orleans, Dec. 7-11.

INSTITUTE ON OPERATING ROOM ADMINISTRATION, Knickerbocker Hotel, Chicago, May, 5, 6.

INSTITUTE ON PHARMACY, Loyola University, Los Angeles, Aug. 24-28.

INSTITUTE ON PUBLIC RELATIONS, Jung Hotel, New Orleans, April 6, 7.

INSTITUTE ON PUBLIC RELATIONS, Princeton University, Princeton, N.J., June 29-July 3.

INSTITUTE ON PURCHASING, Penn Sheraton Hotel, Philadelphia, Oct. 19-23.

INSTITUTE ON SAFETY, Palmer House, Chicago, May 7, 8.

INSTITUTE ON SUPERVISORY TRAINING, Edgewater Beach Hotel, Chicago, Nov. 2-6.

INTERNATIONAL HOSPITAL FEDERATION, London, England, May 25-29.

IOWA CATHOLIC HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 23, 24.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 22.

KANSAS HOSPITAL ASSOCIATION, Lassen Hotel, Wichita, Nov. 12, 13.

LOUISIANA HOSPITAL ASSOCIATION, Jung Hotel, New Orleans, April 6, 7.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Nov. 9, 10.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 20-22.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium—Hotel President, Kansas City, Mo., April 15-17.

NATIONAL LEAGUE FOR NURSING, Biennial Convention, Statler Hotel, Cleveland, June 22-26.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 20-22.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, May 22, 23.

NEW YORK HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 20-22.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 6-9.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 12, 13.

OREGON HOSPITAL ASSOCIATION, Pilot Butte Inn, Bend, Oct. 21-22.

PENNSYLVANIA HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 20-22.

SOUTHEASTERN ASSEMBLY OF NURSE ANESTHETISTS, Jung Hotel, New Orleans, April 8-10.

SOUTHEASTERN HOSPITAL CONFERENCE, Jung Hotel, New Orleans, April 8-10.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, May 8-10.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, May 12-14.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 4-6.

UPPER MIDWEST HOSPITAL CONFERENCE, Radisson Hotel, Minneapolis, May 13-15.

WASHINGTON HOSPITAL ASSOCIATION, Olympic Hotel, Seattle, Sept. 30-Oct. 1.

WASHINGTON HOSPITAL ASSOCIATION, Mid-Year Meeting, Davenport Hotel, Spokane, April 8.

1954

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

NEWS...

Kogel Charges Economies Reduce Patient Care to Dangerous Level

NEW YORK.—Dr. Marcus W. Kogel, New York City's commissioner of hospitals, charged recently that Mayor Vincent R. Impellitteri's economy program is pushing the quality of care of sick persons in the city's hospitals to a "dangerously low" level.

Expressing a "deep foreboding" for the future unless city hospitals get more money, Dr. Kogel submitted a budget request of $119,618,516 for 1953-54, an increase of $7,387,590 over last year's. Ideally, he said, the increase should be closer to $42,000,000.

The commissioner, in a letter to the budget director, said in part:

"This budget proposal, because of the limitations and restrictions imposed upon me, is free from any disturbing suggestions for the solution of any of the critical personnel problems facing the department. It reflects no effort to strengthen the top-level administration; to bring some measure of relief to a desperate nursing situation; to provide for more and better supervision for the thousands of unskilled people working in our hospitals.

"It furnishes no incentive to our professional, scientific personnel and maintains their shamefully low salaries at current levels. It leaves our engineering forces crippled and the maintenance of our buildings a subject of continued criticism. It effectively maintains the status quo."

Dr Kogel said the increase requested was mostly for staffing of new hospital units to be opened in the coming fiscal year. Detailing needs totaling $10,933,048, he said he hoped the sum might be met should the economy drive be relaxed.

In the 1952 annual report of the department of hospitals, Dr. Kogel stated that studies of the new anti-TB drugs at New York City's Sea View Hospital, on Staten Island, have convinced the department that enough weapons and knowledge are now available to make an all-out campaign against TB not only possible but "perhaps even imperative."

In his letter to the mayor, Dr. Kogel stated: "The department has arrived at the conclusion that these drugs, used, as they probably will be, in combination with streptomycin and PAS (para-aminosalicylic acid) will radically change existing concepts of TB medical practice. Given a genuinely effective case-finding program, ambulatory treatment on a wide scale becomes a distinct possibility."

"Even within hospitals themselves," he continued, "the conventional prolonged hospital stay may be modified in favor of measures which will make possible early discharge and home care."

The commissioner pointed out that the city presently has more than 5000 TB patients in its hospitals and that a typical length of hospital stay is one year at a cost to the city of $10 a day per patient. He noted that modifying present practices to reduce lengths of stay to six months would effect a saving of $1825 per patient.

Another development described in the report was the continued progress in the reduction of overcrowding in hospitals, even with an increase in service. The over-all average occupancy rate for the department's 35 hospital facilities was 96.5 per cent, compared to 97.3 per cent in 1951. At the same time the average daily ward census was 20,190, compared to 19,928 in 1951.

This progress Dr. Kogel attributed to an increased use of proprietary nursing homes under a combined program of the departments of hospitals and of welfare; the continued development of the home care program; the opening of the Bird S. Coler Hospital and an increase in the bed complements of hospitals opened in 1950 and 1951. The commissioner said the nursing home program will in time become one of the department's "most important activities."

Of the 7,973,190 days of inpatient care rendered to 275,369 persons during the year, 700,067, or about 9 per cent, were rendered by home care, Dr. Kogel stated. A total of 2,192,366 visits were recorded in the outpatient departments.

Dr. Kogel noted that while Riverside Hospital, a facility for the treatment of pre-adult narcotics users and addicts, should be given one more year "to show what it can do," enough has been learned by now to raise "some doubt" as to its value to the

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community in comparison with its cost. Riverside's budget is $1,000,000 and 173 patients were treated there since it opened July 1.

Another advancement made by the department during last year was the installation of two-way radios in most of the emergency ambulances.

Charges Political Rule Over Newark City Hospital

NEWARK, N.J.—Establishment of a nonpolitical, independent board of trustees for Newark City Hospital was proposed here last month by the Essex County grand jury in a presentment to the superior court charging the hospital was "under the domination of a political segment of the Newark government."

The hospital was making no serious attempt to collect payment for service rendered to "'a great majority' of patients able to pay for their own care," the grand jury charged.

Recommending that a new authority should be created to administer the affairs of the hospital, the presentment said an investigation of the hospital "leaves us with a strong conviction that this highly essential function cannot be effective as long as it is under the domination of a political segment of the Newark government."

Army Hospitals Approve Audio-Visual Call System

WASHINGTON, D.C.—Results of the tests and evaluations of the audio-visual nurse call systems at Fitzsimons Army Hospital, Denver, and Valley Forge Army Hospital, Phoenixville, Pa., show that the use of such systems saves the time of nurses and doctors, increases nurse availability and improves patient care.

Because of this, the army medical service plans to install the system in the seven new permanent hospitals planned for army posts in this country, which will be constructed early this year. They will be at Fort Benning, Ga.; Fort Bragg, N.C.; Fort Knox, Ky.; Fort Riley, Kan.; Fort Belvoir, Va.; Fort Monmouth, N.J., and at Fort Dix, N.J.

The electronic communication system permits a two-way conversation between the nurse at her duty station and the bed patient. A nonlocking call button within reach of the patient sounds a chime and lights the signal light on the nurses' control station, thus identifying the calling patient; lights the corridor dome right above the patient's ward or room door; sounds buzzer, and lights duty station lights in utility room, diet kitchen, and other work areas. The system also permits simultaneous multiple calls, it was explained.

When the nurse answers the patient, the line automatically opens for a two-way conversation and extinguishes the call lights.

The two-way conversation enables the nurse to determine the patient's needs and to take care of them on a single visit. Often the requirements can be furnished by ancillary personnel, thereby relieving the nurse of functions that can be performed by orderlies.

During ward rounds, members of the medical staff have found the audio-visual system useful in calling the nurses' station for equipment and supplies.

The army has found that the audio-

NEWS...

visual system enables the patient to communicate with his nurse at any time, thus making his needs known sooner and met faster. Emergency situations receive immediate attention and suffering is minimized. By "listening in" to each room or patient area at regular intervals the nurse can quickly locate and attend to a patient in distress. In addition, the patient benefits from a new feeling of security with the reassuring voice of the nurse at his bedside at all times, an important factor in all recovery, army officials explained.

While the cost of the audio-visual nurse call system is approximately twice that of the light and buzzer system, the resulting benefits are such that the army surgeon general plans to install it in every new permanent army hospital, it was announced.

30 Illinois Schools Admit Negro Nursing Students

CHICAGO.—Thirty out of 81 nurses training schools studied recently in Chicago and other areas have now admitted Negro students. In a comparable study made in 1950 only 18 out of 71 schools were reported to have admitted Negroes, according to a report released recently by the Illinois Commission on Human Relations.

Another 33 schools which presently have no Negroes enrolled said that their schools are open to Negro applicants. There were only 25 schools in this category in 1950. Only five schools stated that their policies prohibited admission to Negro students in the 1952 survey, as compared to 18 in 1950.

In commenting on the survey, Russell B. Babcock, executive director of the commission, said:

"The increase in the number of schools of nursing which now admit Negroes is encouraging, but the change in policy must be more than a paper gain. We must make sure that it is followed by an appreciable gain in enrollment of Negro students.

"Particularly, in view of the current shortage of trained nurses, young women of all races should be encouraged to enter the nursing profession. Counselors can help by seeing to it that high school students are guided into the proper preparatory courses."

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NEWS...

Buzz Sessions Conclude Wisconsin Meeting

(Continued From Page 152)

any work is done a survey of all staff doctors be made to obtain their opinions on ways and means they can help reduce costs and make more efficient use of personnel. This gets the doctors interested. Miss Wright also emphasized the importance of making a survey of patient opinion and employe opinion before work is started.

In discussing the correlation between the central sterile supply room and the various nursing units, Miss Wright urged that a 24 hour supply of all central sterile standard supply items used on the nursing unit be kept on each unit. She said that experience has proved that keeping such a supply on hand will greatly reduce the number of requisitions and the amount of messenger service needed to handle the work in the nursing unit.

Dave C. Reynolds of Madison General Hospital, Madison, discussed the work an active hospital council in the area has done to get adequate payment for indigents from the Dane County Welfare Department. The Madison hospital group proposed that the board of supervisors of Dane County pay the hospitals on the basis of their regular ward billings, less a discount of 5 per cent. Following negotiations, it was agreed that regular ward billings less a discount of 10 per cent would be the method of payment. This has resulted in a substantial increase in the payment from the Dane County Welfare Department to the hospitals.

The association's regular yearly award of merit was made to Grace T. Crafts, who recently retired as administrator of Madison General Hospital. Because Miss Crafts was out of the country on vacation, the award was accepted in her behalf by Joseph E. Norby.

Dr. Edwin L. Crosby, president of the American Hospital Association and director of the Joint Commission on the Accreditation of Hospitals, was the luncheon speaker. Dr. Crosby urged hospital people to bring the spiritual aspects of their lives into their work. Listing important areas of a hospital in which research is needed, he picked out medical staff relations as one of the more important problem areas. He stressed the importance of establishing the pro-

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NEWS...

posed institute of hospital affairs to carry on the research needed in the hospital field.

Most of the afternoon was given over to a "buzz session," with George Bugbee of the American Hospital Association as its guide. After some preliminary discussions, the audience voted to carry the following problems into separate buzz sessions: (1) shortage of nursing staff at all levels; (2) high cost of hospital care; (3) problems of training hospital personnel adequately for their jobs, and (4) administrative delegation of duties to assistants.

The buzz session on lack of nursing personnel pointed up the fact that intelligent, trained, well informed, and supervised personnel can make better use of available personnel. Miss Anderson, director of nurses at Columbia Hospital, Milwaukee, declared that hospitals have failed to use public and private educational facilities to the full extent in the training of practical nurses. One of the keys to the solution of the nurse shortage, she declared, is the formation of many new schools for practical nurses. She thinks these schools can be operated best in cooperation with public educational facilities.

One group recommended that hospitals stop thinking that their costs are too high and begin telling the public just how hospital costs develop. The group recommended that hospitals point out that their rates are really a bargain, when compared to other things that the public buys. E. W. Jones, vice president of the Modern Hospital Publishing Company, Inc. pointed out that the present average cost of $20 a day in the acute short-term general hospital means only 84 cents an hour for high grade patient care. However, we must not overlook any opportunity to reduce costs, he said, calling attention to the methods engineering and job analysis work done by Marion Wright and Professor Clark at Harper Hospital and the even more extensive studies being made by the Cleveland Hospital Council as essential to major economies in hospital operation.

Mr. Jones predicted that even with the most extensive type of management engineering studies we would probably be unable to reduce costs per patient per day by more than 5 per cent. It is important, he said,

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NEWS...

that the public know about such studies so they will realize that every possible effort is being made to operate hospitals on an efficient basis.

Riley McDavid, administrator of Kenosha Hospital, Kenosha, urged hospital people to do a more efficient job of purchasing. He called attention to the excellent material on simplification and standardization in the American Hospital Association's administrative guide issue and the *Hospital Purchasing File*.

Active cooperation from staff doctors is essential to obtaining full results from any type of employe training program, it was pointed out at the session on personnel training. Mr. Jones urged that wherever possible hospitals get in touch with universities or colleges in their areas to see if they can offer facilities for supervisory training programs. He discussed the work of the American Hospital Association's commission on human relations in the hospital organization and the study being made for this commission by the department of labor and industrial relations at Cornell University. He said the commission hopes that the Cornell studies will result in an excellent guide to hospital people in setting up supervisory training programs.

The buzz session discussing the delegation of responsibilities to assistants by the administrators was reported on by Sister Thomas of the college of nursing, Marquette University. Administrators must make their assistants understand that their advice and criticism are really wanted, the group stressed. It is necessary that the administrator first have a clear-cut understanding as to the position of his trustees, his assistants, and the staff doctors in the whole function of policy-making and actual administration.

The following officers were elected: president, the Rev. A. H. Schmeuszer, administrator of Evangelical Deaconess Hospital, Milwaukee; president-elect, Mary Evans, administrator of Beloit Municipal Hospital; first vice president, David C. Reynold, administrator of Madison General Hospital; second vice president, Riley McDavid, administrator of Kenosha Hospital; treasurer, Robert E. Griffiths, administrator of the Burlington Memorial Hospital, and trustee, Edmond Goebel, director of the Catholic Hospital Diocese.

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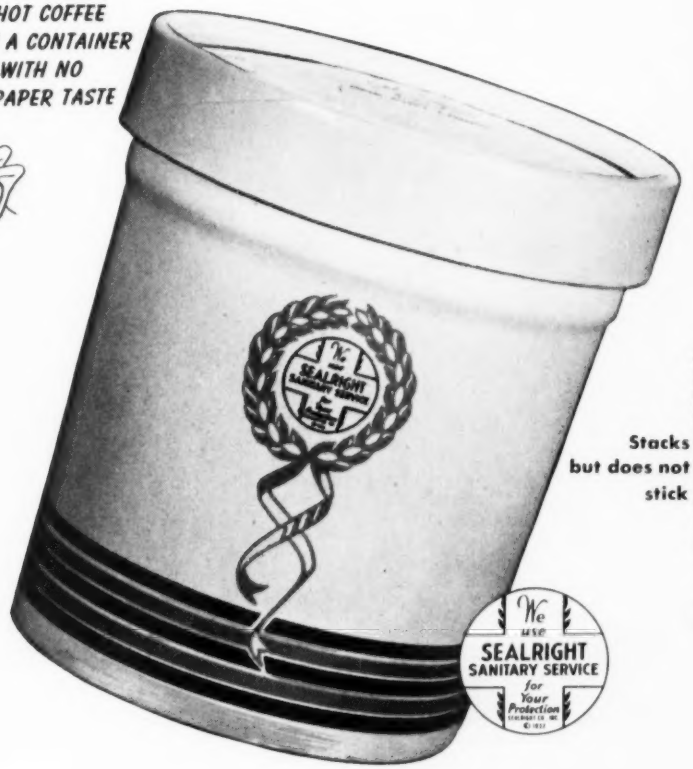

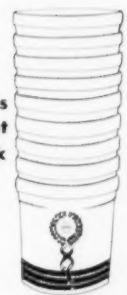

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ABOUT PEOPLE

(Continued From Page 84)

pital, Inc., Morganton, N.C. Formerly administrator of the King's Daughters' Hospital, Staunton, Va., Mr. Brothers is a member of the American College of Hospital Administrators.

Harry Franklin Habel is the new administrator of Meyersdale Community Hospital, Meyersdale, Pa.

Norman M. Brayshaw has been named administrator of Southern Nevada Memorial Hospital, Las Vegas.

Sidney J. Thompson is now administrator of Chambers County Hospital, Anahuac, Tex.

Stacy Johnson has assumed his new duties as administrator of Memorial Hospital, Clarksville, Tenn., which will be completed the latter part of this year. Mr. Johnson, who attended the University of Toronto School of Hospital Administration, also has served as purchasing agent of Children's Hospital, Washington, D.C., and as administrative resident and later assistant administrator of East Tennessee Baptist Hospital, Knoxville.

Dr. Thomas B. Spencer and **Tracy F. Storch** have been appointed assistant directors of New York Hospital, New York City. Both have been members of the hospital's staff since 1952, Dr. Spencer as director of the outpatient department and Mr. Storch as executive assistant for services and supplies. Before going to New York Hospital Dr. Spencer was executive director of the committee on medical sciences, Research and Development Board, Department of Defense. Mr. Storch, a graduate of the School of Public Health, Columbia University, previously was director of the North Country Hospitals in upstate New York, which included hospitals at Gouverneur, Canton and Alexandria Bay.

Genevieve Jeffreys is the newly appointed administrator of Crawford County Memorial Hospital, Denison, Iowa.

Thomas Vaughn Noland, who recently returned from a tour of active duty in the air forces, has been named administrator of the new Claiborne County Hospital, Port Gibson, Miss.

Dr. George D. Kettelkamp, superintendent and medical director of Robert Koch Hospital, Koch, Mo., since 1929, has retired. Dr. Kettelkamp has been in the service of the city for the last 31 years.

Dr. David B. Wilson has been named director of the University of Mississippi Hospital now under construction at Jackson. The hospital will be a part of the state medical college and center. Dr. Wilson, who has been associated with the Mississippi Commission on Hospital Care since 1951, is a nominee of the American College of Hospital Administrators.

William I. Leonard, the new superintendent of the Burlington County Mental Hospital, New Lisbon, N.J., will continue his other duties as superintendent of the Burlington County Welfare Home, New Lisbon. Mr. Leonard has been superintendent at the welfare home since 1942. In his new position Mr. Leonard succeeded **Walter T. Stewart,** who died last October.

Vernon Stutzman has resigned as administrator of Staten Island Hospital, Staten Island, N.Y., to become assistant director of the Methodist Hospital of Brooklyn, N.Y. His successor at Staten Island is **John F. Miller,** formerly administrator of Union Hospital, Dover, Ohio. Mr. Miller will be succeeded at Union Hospital by **Harold P. Alden,** formerly administrator of Green's Eye Hospital, San Francisco. All three men

are graduates of the Columbia University course in hospital administration. Mr. Stutzman served his administrative residency at the Jewish Hospital of Brooklyn, N.Y. He was later appointed assistant director of the institution. He is a member of the American College of Hospital Administrators and a personal member of the American Hospital Association. Mr. Miller and Mr. Alden are both nominees of the American College of Hospital Administrators.

Ralph L. Outten has been named administrator of South Side Hospital, Pittsburgh, succeeding **Gertrude L. Heatly,** whose death was reported in the March issue. Mr. Outten has been assistant director of Montefiore Hospital, Pittsburgh, for the last seven years, and before then was associated with the Memorial Hospital, Wilmington, Del., as assistant director. He is a member of the American Hospital Association, the Hospital Association of Pennsylvania and the Southwestern Hospital Conference of Pennsylvania.

Harry J. Tamplain is the new assistant director of Foundation Hospital of Alton Ochsner Medical Foundation, New Orleans. Mr. Tamplain was appointed chief accountant at Foundation Hospital on Sept. 1, 1948, and administrative assistant on Oct. 1, 1952.

Frank B. Adair is the new administrator of Robert R. Moton Hospital, Tulsa, Okla., which is now a chartered voluntary institution. Mr. Adair, who was the first Negro to serve an administrative residency in an American voluntary hospital, Sydenham Hospital of New York City, has also served as assistant director and acting director of Sydenham, and later as administrator of Community Hospital, Wilmington, N.C.

Frank B. Adair

Richard Collett assumed his new duties April 1 as acting director of Long Island College Hospital, Brooklyn, N.Y. He succeeded **Bernard McDermott,** director of the hospital for 19 years, whose retirement March 31 was announced in the March issue. Mr. Collett, who joined the hospital's administrative staff in 1935,

Richard Collett

has been assistant director for the last seven years. He is president of the Hospital Purchasing Club of New York City, and a member of the research committee of the Hospital Bureau of Standards and Supplies and of the Hospital Council of Brooklyn.

Leslie Pinckney Hill is the new administrator of Mercy-Douglass Hospital, Philadelphia.

Opal C. Darling, R.N., has been named administrator of Memorial Hospital at Sedro Woolley, Wash., succeeding **Gertrude Linn,** who has been associated with the hospital for the last 21 years.

Carl Ibach, formerly business manager at the hospital, has resigned to become officer manager at Vancouver Memorial Hospital, Vancouver, Wash.

Robert T. Besserer, administrator of Winter Haven Hospital, Winter Haven, Fla., since 1948, has resigned to accept a similar position at the new Hall County Hospital, Gainesville, Ga., succeeding **W. N. Walters,** whose retirement was announced in the March issue. He is a nominee of the American College of Hospital Administrators.

R. B. Shipp has succeeded **R. T. Anderson** as administrator at Skyline Hospital, White Salmon, Wash. Mr. Shipp previously was administrator of the Glacier County Memorial Hospital, Cut Bank, Mont., a position he held for three and a half years.

Thomas Bess Jr. has been appointed administrator of Gnaden Huetten Memorial Hospital, Lehighton, Pa. For the last seven years he has been administrator of Potomac Valley Hospital, Keyser, W.Va. He is a director and vice president of the West Virginia Hospital Association and of the Upper Monongahela Hospital Association.

Nelson Ammons is the new administrator of Olympic Memorial Hospital, Port Angeles, Wash., succeeding **Willis Parr,** acting administrator for several months. Mr. Ammons was previously administrator of Samaritan Hospital, Nampa, Idaho, for 10 years. He is a past president of the Idaho Hospital Association and a member of the American College of Hospital Administrators.

Robert E. Wallace is now administrator of Wood River Township Hospital, Wood River, Ill. Formerly, he was assistant administrator of Beyer Memorial Hospital, Ypsilanti, Mich.

Dr. Arthur K. Besley has resigned as administrator of Uniontown Hospital, Uniontown, Pa., a position he has

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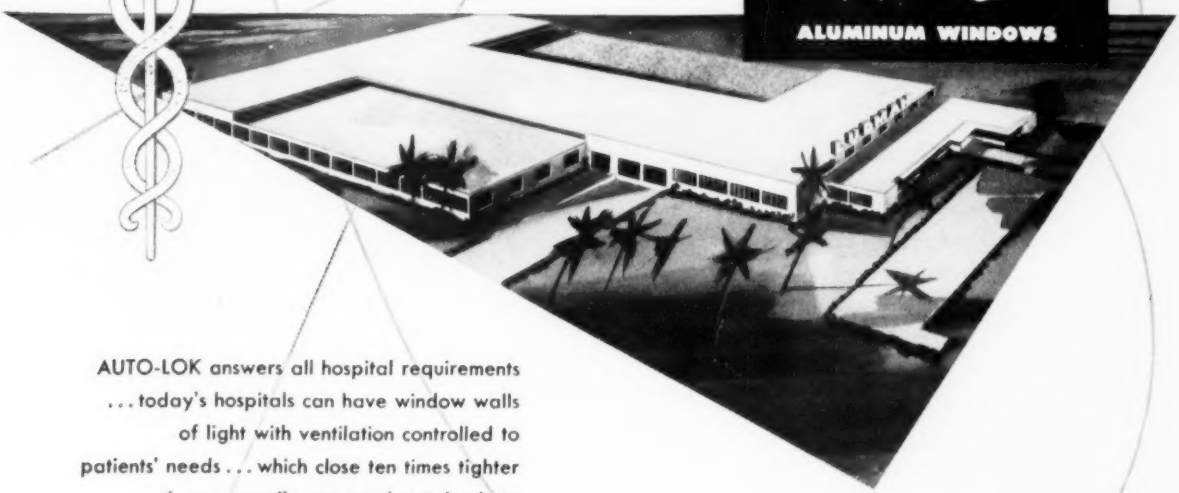

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held for almost two years. **Dr. Jacob Goldblum,** radiologist, is now acting administrator of the hospital.

Marvin J. Lawrence, formerly assistant executive director of the Jewish Hospital Association, Cincinnati, recently became director of North End Clinic, Detroit, which is an affiliate of the new Sinai Hospital there. In the last issue he was erroneously called the former director of the clinic.

Department Heads

Dr. Ralph Friedlander has been appointed as the full-time director of surgery at the Bronx Hospital, New York City. Previously Dr. Friedlander was chief of surgery and chief of thoracic surgery at the Veterans Administration Hospital, Brooklyn, N.Y. He was also an associate clinical professor of surgery at the New York State University College of Medicine, Brooklyn. Dr. Friedlander, who received his M.D. degree from Rush Medical College, University of Chicago, in 1938, took graduate training in surgery at Michael Reese Hospital, Chicago, and at Bellevue and Mount Sinai hospitals in New York City. He served with the army medical corps from 1942 to 1946 as a senior surgeon. A fellow of the American College of Surgeons and a diplomate of the American Board of Surgery, he is also an associate member of the American Association for Thoracic Surgery.

Joseph J. Hayes Jr. has assumed his new duties as controller and assistant to **Dr. Raymond S. Leopold,** executive vice president of Hahnemann Hospital, Philadelphia. Mr. Hayes was formerly assistant administrator of Women's Medical College Hospital, Philadelphia. He is a certified public accountant and chairman of the Philadelphia Purchasing Group.

Mabel F. Selfe

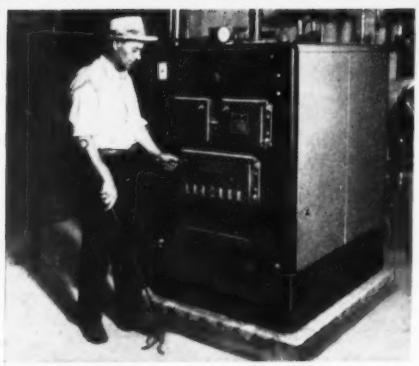
Mabel F. Selfe has been appointed director of nursing at Cleveland Clinic Hospital, Cleveland. Miss Selfe was director of nursing and assistant superintendent at Mansfield General Hospital, Mansfield, Ohio, from 1936 to 1946 and previously had been assistant director of nursing at St. Luke's Hospital, Cleveland, for six years.

Miss Selfe, a graduate of Battle Creek College school of nursing, Battle Creek, Mich., is a member of the National League of Nursing and the Ohio State Nurses Association.

Margaret E. Benson, R.N., is the newly appointed chief of the infectious and tropical diseases nursing section of the Clinical Center at the National Institutes of Health of the U.S. Public Health Service. The Clinical Center is a new facility nearing completion on the grounds of the National Institutes of Health, Bethesda, Md. Miss Benson, who directed a study of nursing in the state of Minnesota in 1948, was appointed special consultant to the Division of Nursing Resources, Bureau of Medical Services, U.S. Public Health Service in 1951.

Phil Holimann has assumed his new duties as building service manager at Passavant Memorial Hospital, Chicago, succeeding **Linda Benson Clark.** Before joining the staff of Passavant, Mr. Holimann was associated with Edgewater Hospital, Chicago. He formerly served as administrator of German personnel in the 98th General Army Hospital in Germany.

Mary Lou Shaw, assistant housekeeper for the last two years at Passa-



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vant has accepted the position of executive housekeeper at the Louis Weiss Memorial Hospital, Chicago.

Miscellaneous

Dr. Louis L. Williams Jr., a career officer of the U.S. Public Health Service since 1915, has retired. At the time of his retirement he was chief of the Division of International Health, a position he had held since 1948. A specialist in malaria control research for 26 years, Dr. Williams was a member of the U.S. Delegation to the International Health Conference in New York in 1946; a delegate to the Pan American Sanitary Conference in Caracas, Venezuela, in 1947, and a member of the organizing committee, fourth International Congress on Tropical Medicine and Malaria in 1947. He is a member of the American Academy of Tropical Medicine, American Medical Association; American Public Health Association, the board of directors of the Gorgas Memorial Institute of Tropical and Preventive Medicine, and a fellow of the American Association for the Advancement of Science. He also is a past president of the National Malaria Society and of the American Society of Tropical Medicine.

Samuel S. Virts, public relations and personnel director of St. Mary's Hospital, Evansville, Ind., has resigned. He will establish a consulting firm in hospital personnel and public relations in San Jose, Calif. Mr. Virts, who has been serving as secretary of the Evansville Area Hospital Council, will be succeeded in that position by **B. B. McDonald,** business manager of Good Samaritan Hospital, Vincennes, Ind.

Dr. Charles U. Letourneau has been named associate director of the hospital administration program and professorial lecturer at Northwestern University. Dr. Letourneau, who received his master's degree in hospital administration at Northwestern in 1951, is secretary of the council on professional practice of the American Hospital Association. He served as junior intern in 1937-38 and admitting officer in 1939 at Montreal General Hospital, Montreal, Que. From 1939 to 1946 Dr. Letourneau served in the medical branch of the Royal Canadian Army. For the following four years, up to the time he attended Northwestern University, he was superintendent of a veterans' hospital in Montreal.

Susan S. Jenkins, executive secretary of the Kansas City Area Hospital

Council has resigned, effective May 1. Miss Jenkins has held the council post on a part-time basis for the last 10 years, in addition to her position as assistant to the director of the Kansas City Blue Cross and Blue Shield plans.

Trustees

Mrs. James S. Linburn, president of the board of directors at Blythedale, an orthopedic hospital and rehabilitation center for children located at Valhalla, N.Y., has announced the addition of the following new directors: **Mrs. Joseph L. Abrams, Mrs. Edgar M. Cullman, Walter W. Hess Jr., Joseph Klee, Leonard Wallstein Jr.,** and **William F. Woff Jr.**

Deaths

Dr. Bernard A. O'Connor, medical director of St. Michael's Hospital, Newark, N.J., died recently. Dr. O'Connor had been a member of the surgical staff of West Hudson Hospital, Kearny, N.J., of which he was named director in 1928. He was named director of St. Michael's Hospital in 1938. Dr. O'Connor was a past president of the Guild of Catholic Doctors of the archdiocese of Newark.

Dr. Morris Mason, founder of Royal Hospital, the Bronx, N.Y., and the Kew Gardens General Hospital, Queens, died recently. Dr. Mason, who founded the Royal Hospital in 1928, was its general manager for many years.

Mother M. Damian, a member of the Roman Catholic Order of St. Francis, who was administrator of St. Mary's Hospital, West Palm Beach, Fla., from 1940 to 1946, died February 27. She had been administrator at St. Francis Hospital, Miami Beach, from 1934 to 1940, and also had worked in hospitals in Boston and New York.

Dr. Thomas I. Price, general medical superintendent of the New York City Department of Hospitals from 1944 to 1948, died March 6. Formerly assistant to the medical superintendent of Kings County Hospital, New York City, Dr. Price later had held a similar post at Central Neurological Hospital on Welfare Island. He was assigned to the U.S. Army Medical College in World War I and in 1918 was named head of the Central Neurological Hospital. In 1922 he organized the New York City Cancer Institute in cooperation with the late **Dr. Isaac Levine.** He also had served for six years as medical superintendent of City Hospital, New York City.

Red Cross Nurse's Aides May Work in Sanitariums

NEW YORK CITY.—Red Cross volunteer nurse's aides, as a result of a recent policy change, are now allowed to serve in tuberculosis hospitals, provided the following conditions are met:

Professional nurse supervision of the unit must be maintained at the time the aide is serving, and adequate and accessible handwashing equipment, preferably foot-operated or knee-operated, must be provided. All personnel working in these units must follow a standard manual of procedure for safe handling and disposal of contaminated materials.

Hospitals also must be willing to assist in the health examination, including tuberculin test and chest x-ray, of aides before their assignment and to give follow-up tuberculin tests and chest x-rays every six months. Only selected patients, who are willing and able to observe precautionary measures, can have aides assigned to them.

THE BOOKSHELF

WHEN DOCTORS ARE PATIENTS. *Edited by Max Pinner M.D. and Benjamin F. Miller M.D. New York: W. W. Norton Company, Inc. $3.95.*

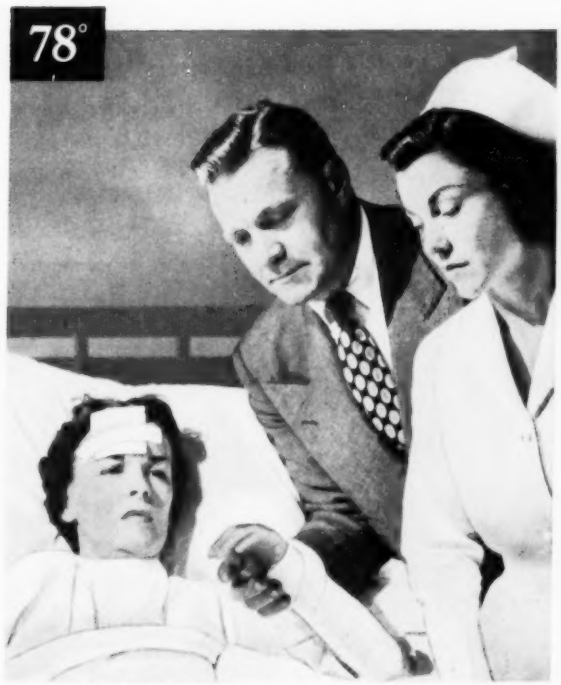
The idea of this volume occurred to the late Dr. Max Pinner at Montefiore Hospital, New York City, where he served as chief of the division of pulmonary diseases. He was being reminded on occasion of the illness which finally closed his useful life and felt that no one could possibly know more about its details than he himself. His decision to share this knowledge followed naturally for this distinguished clinician pathologist and editor. He spelled out his own case history so that his findings could be interpreted alongside those which were worked out by his doctors. He then invited a selected group of colleagues to follow his example. Much of the groundwork for this volume was done by him, but the lion's share of the editing and compilation after his death fell to his scholarly friend and Montefiore patient, Dr. Benjamin F. Miller, now of the research staff of the Peter Bent Brigham Hospital in Boston.

It is one thing to deal with cold scientific facts and figures objectively. The test tube is inanimate and lends itself to exact interpretation. What happens *in vivo*, however, is not always the same thing that happens *in vitro*, even though the conditions of the experiment look alike on the surface. Every clinician has discovered this difference for himself. It is the business of the physician to approximate the exact sciences in the diagnostic and therapeutic work which lies before him so compellingly. In this effort the subjective point of view should be eagerly sought. Since the physician is obviously the best interpreter of his own physical, and particularly mental, reactions to his own signs and symptoms during illness, he becomes a star witness when his case is under consideration.

THEY LIVED TO TELL IT

This volume is a compilation of chapters by 33 high ranking physicians who have suffered a variety of illnesses and lived to tell the tale in such a way as to be most useful to their colleagues as well as to their patients. In my opinion, "When Doctors Are Patients" is one of the most helpful books to come off the printing press in recent years. Every executive working in a modern hospital should have a copy on his shelf, and there also should be copies in the medical library and in the patients' library. It should get thorough circulation. This volume is as fascinating as it is useful, and I earnestly hope that it will stimulate a vogue among physician-scientists to continue the record of their personal experiences during illness as a debt which they owe to medical education. Only he who has endured suffering can fully understand its effects. "He jests at scars that never felt a wound."—E. M. BLUESTONE, M.D., *consultant, Montefiore Hospital, New York City.*

In room 303, the patient only needs a 70° temperature since he is nearing full recovery and is ready to be discharged. Because this hospital has Individual Room Temperature Control, it's possible to supply the right temperature for each patient's condition.



In room 403, the room above, the Honeywell Hospital Thermostat is set at 78° to help the recuperative process of this patient, who suffered shock in an accident. With a thermostat in each room, physicians can prescribe the exact temperature each patient needs.

A mark of a modern hospital is a thermostat in every room

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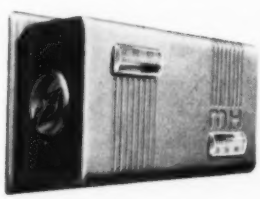
For complete facts on Honeywell Controls for your hospital, call your local Honeywell office – there are 104 in key cities throughout the nation. Or for literature, write Honeywell, Dept. MH-4-95, 351 E. Ohio St., Chicago 11, Ill.



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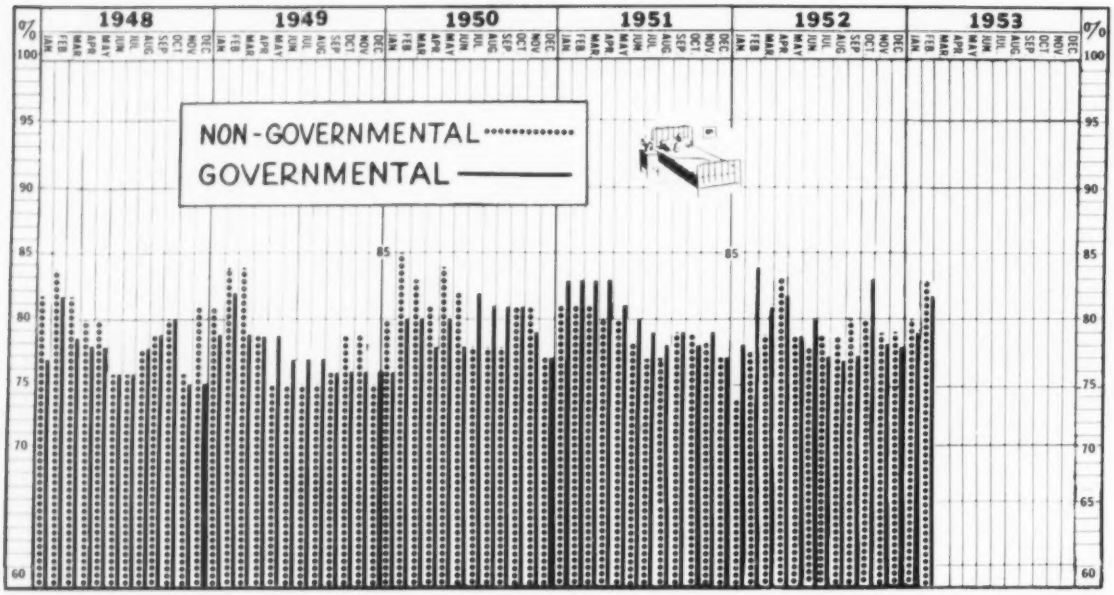
Hospital Construction Doubles 1952 Figure



Occupancy Chart figures for the month of February are: voluntary hospitals, 83 per cent; government hospitals, 82.2 per cent. These show little change from last year's 81.4 and 82.9 per cent, respectively.

However, small differences are not the case in new hospital construction. During the latest two-week period ending March 23, new hospital building amounted to $77,445,029, whereas the 1952 total for the same period was $32,029,752. Year-to-date construction has reached $235,684,685, or almost 2.5 times greater than the reported total of March 1952, which was $99,780,465. Twenty-two of the 52 reported projects were hospitals.

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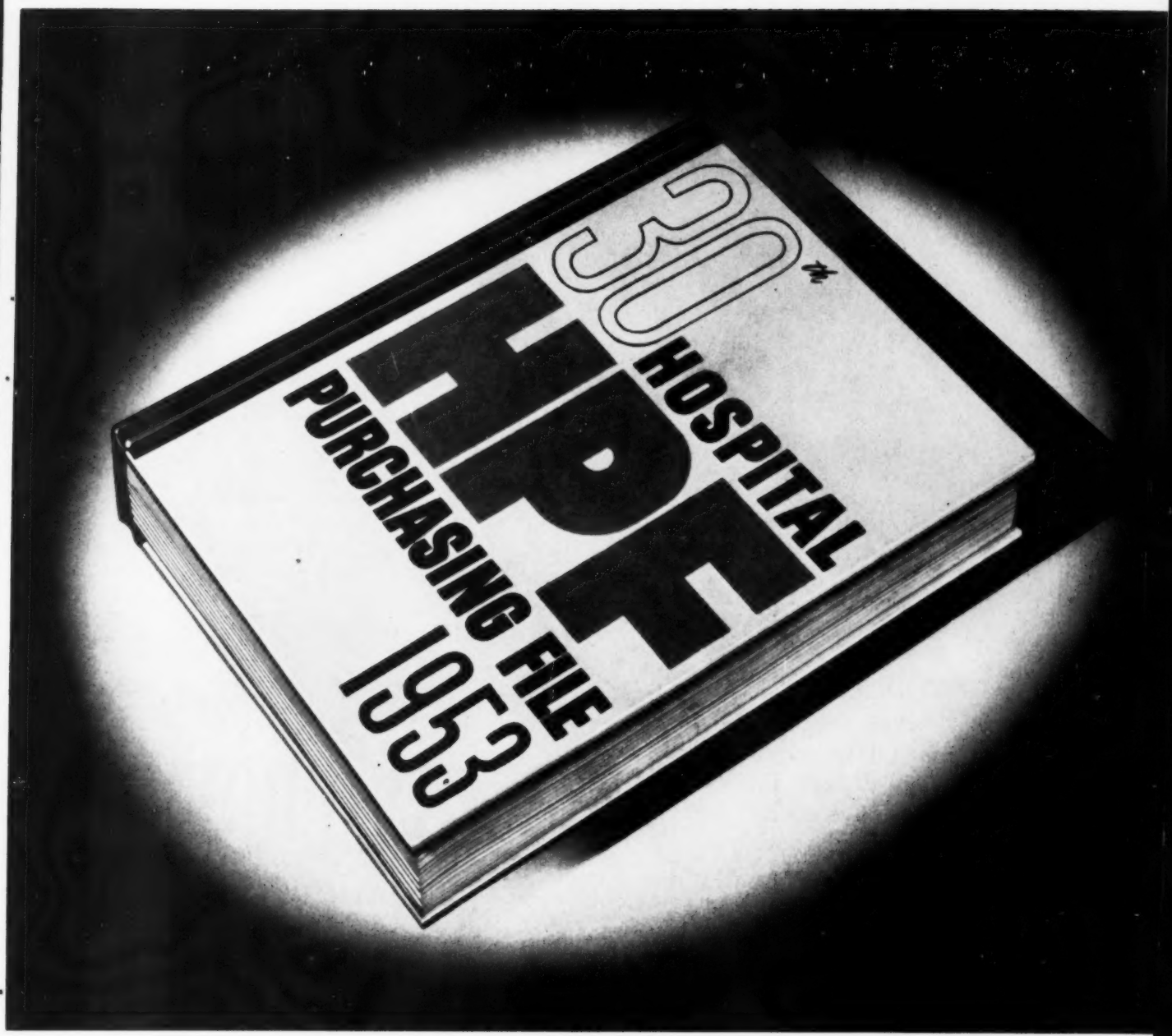

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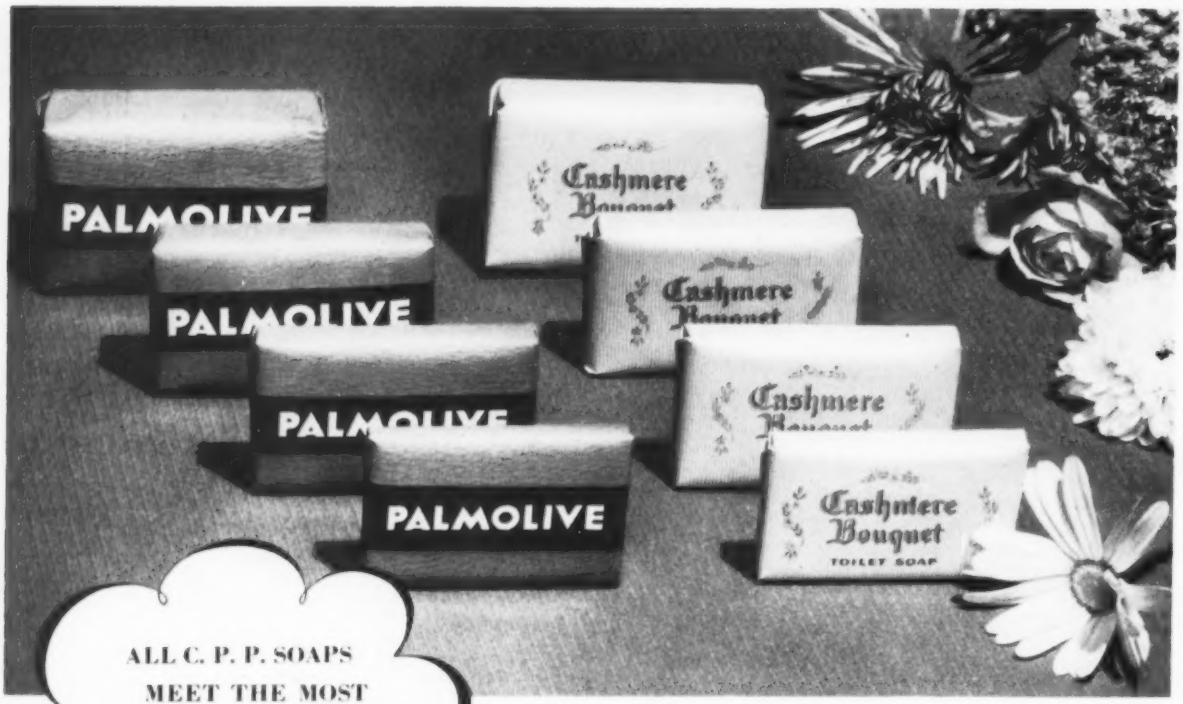

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DIRECTORSHIP or ASSISTANCY—Of hospital or clinic; B.A. and M.A. degrees in Business Administration, Iowa University; 3 years' experience as state college accountant-bursar-business manager; 6 years state college business teaching; wife a registered nurse, Iowa. MW 87, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ENGINEER—Technical graduate; 20 years experience; thoroughly capable all phases engineering and maintenance. Address: Engineer, 331 West Marquette Road, Chicago 21, Illinois.

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PATHOLOGIST—Diplomate, Pathologic Anatomy and Clinical Pathology; three years, pathologist, teaching hospital and on faculty medical school; five years, director of pathology, 250-bed hospital.

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ANESTHETIST—Wanted to complete staff of three; 275-bed hospital located in the state capital and business center of newly developing North Dakota oil industry; sick leave after six months; two weeks paid vacation after one year. MO 32, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Excellent opportunity; 102-bed general hospital. Write or phone, Administrator, Northeastern Hospital, Philadelphia 34, Pennsylvania.

ANESTHETIST—Nurse; general hospital, 700 beds; salary $3800-$4200, yearly increments $100; vacation and sick time; full maintenance provided. Address: A. G. Chmelnik, M.D., Department of Anesthesiology, City Hospital, 116 Fairmount Avenue, Newark, New Jersey.

ANESTHETIST—Nurse; for approved pediatric hospital. Write, Administrator, Milwaukee Children's Hospital, 721 North 17th Street, Milwaukee 3, Wisconsin.

(Continued on page 214)

ANESTHETIST—For small hospital; excellent working conditions plus good equipment; with or without complete maintenance; base salary $325; position available April 1st. Apply, Highland Hospital, Belvidere, Illinois.

ANESTHETIST—Registered nurse; 153-bed general hospital; attractive college town 23 miles from Philadelphia; one month vacation, sick leave; alternate week-ends and night calls with two other anesthetists; state desired salary in reply. Norman Skillman, Director, Chester County Hospital, West Chester, Pennsylvania.

ANESTHETIST—Second; 75-bed new hospital, near Baltimore and Philadelphia; $400 month, usual benefits; available June. Write, Administrator, Harford Memorial Hospital, Havre de Grace, Maryland.

ANESTHETIST—Nurse; 36-bed hospital; salary open; liberal employee benefits; located 75 miles from Sun Valley. Gooding County Memorial Hospital, Gooding, Idaho.

ANESTHETIST—Nurse; for 125-bed general hospital; salary open; full maintenance. Apply to Superintendent, Maine Eye and Ear Infirmary, Portland, Maine.

ANESTHETIST—Nurse; for 300-bed general hospital; midwest industrial city; A.C.S. and A.M.A. approved; modern facilities; comfortable living accommodations; paid vacation; pleasant working conditions. Apply: Administrator, Mercy Hospital, Hamilton, Ohio.

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ANESTHETISTS—Nurse; two vacancies immediately available; full time medical anesthetist in charge of department; new modern 115-bed hospital. Mount Sinai Hospital, Hartford, Connecticut.

DIETITIAN—Registered; for 120-bed general hospital with school of nursing; building program to increase to 175 beds and include new dietary unit; good working conditions with 40-hour week; salary open; midwest town of 75,000 population. Apply, MO 28, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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DIRECTOR—Educational; salary $6000 to qualified person; accredited school; college affiliation; modern facilities; 250-bed hospital; Chicago area. MO 29, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—For 375-bed fully approved hospital; school of nursing with 100 students; 17 miles from New York City; one-half hour train service; salary open. Apply, Superintendent, New Rochelle Hospital, New Rochelle, New York.

DIRECTRESS OF NURSES—300-bed fully approved general hospital with accredited school of nursing; located in a beautiful resort city; personnel policies in accordance with S.N.A.; Degree in Nursing Education required; full maintenance, salary open. Apply, Atlantic City Hospital, Atlantic City, New Jersey.

DIRECTOR OF NURSING—Assistant; director of nursing service; man or woman with knowledge of modern approaches to supervision; salary to $6500; 240-bed hospital; midwest. MO 30, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSING—Assistant; San Jose Hospital, new addition completed, San Jose, California; college town, only one hour from San Francisco; liberal salary and personnel policies, including 40-hour week; Baccalaureate Degree in Nursing and experience in administration or supervision. Write, Director of Nursing, San Jose Hospital, San Jose, California.

INSTRUCTOR—Clinical; to teach orthopedics and the communicable diseases; salary for degree and experience $3804 to $4164; retirement program and social security; 441-bed hospital in a beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTOR—Clinical; obstetrics and medical; immediate opening; 200 student body, one class annually; good personnel policies and salary. Apply, Director, School of Nursing, St. Francis Hospital, Peoria, Illinois.

INSTRUCTOR—Nursing arts; for 192-bed hospital, 70 students; immediate opening; new educational department under construction; salary open. Apply to Director of Nursing, House of the Good Samaritan, Watertown, New York.

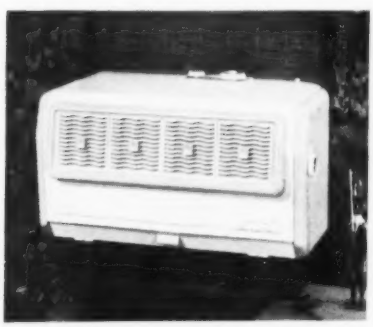
INSTRUCTOR—Nursing arts; for 137-bed hospital, approved school of nursing; B.S. Degree in Nursing Education; salary depending on qualifications and experience; liberal personnel policies. Apply, Director of Nurses, Methodist Hospital, Madison 3, Wisconsin.

(Continued on page 216)

From **PHILCO** *the Leader... a ½ h.p. Air Conditioner at New Low Price!*

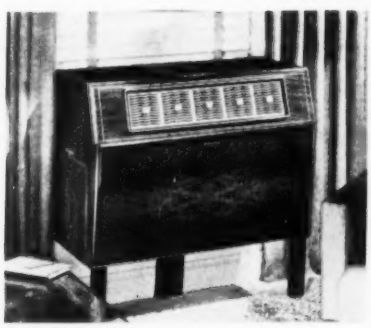
Designed for Hospital Rooms and Offices

Again Philco leadership makes value history! Here for 1953, at the lowest price in the industry, is a full-quality ½ H.P. Air Conditioner that cools, dehumidifies, filters and circulates the air. Yes, *true* air conditioning, powered by a sealed-in-oil electric refrigerating system covered by five-year warranty. Mail coupon below for full details of the new Philco Model 50-J, housed in handsome Mahogany-finish cabinet.



COOLS on Hot Days... HEATS on Cool Days

New for 1953—Thermo-Cool Philco Model 86-JL for *double-duty* service! Reverse cycle ¾ H.P. system *cools or heats* the air. Plus Automatic Temperature Control and newest Philco advanced features. Arctic Dawn color styling.



Consolette Unit Does Not Extend Outside Window

Another Philco development—true air conditioning in space-saving cabinet, specially designed for hard-to-fit rooms and casement windows. With Automatic Temperature Control and 1 H.P. unit—Philco Model 1104-J.

Get the Full Story of Newest Philco Air Conditioner Developments

MAIL COUPON TODAY

Philco Air Conditioners, Dept. D3
C and Tioga Streets
Philadelphia 34, Penna.

Gentlemen: Please mail me free Philco booklet, with news of America's lowest priced ½H.P. full-quality Air Conditioner.

Name.....

Address.....

.....

PHILCO...World's Largest Selling Room Air Conditioners for 16 Straight Years

classified advertising

POSITIONS OPEN

INSTRUCTOR—Nursing arts; 450-bed hospital; 150 student nurses; school accredited; 44-hour week; 1 month vacation; 2 weeks sick leave; salary $220 and up depending on preparation and experience, plus maintenance or $35 allowance if living out; position open May 1. Apply, Dean, School of Nursing of Medical College of South Carolina and Roper Hospital, Charleston, South Carolina.

LIBRARIAN—Medical records; for completely modern 150-bed general hospital; attractive town of 40,000; minimum starting salary $300. For details write: Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

MISCELLANEOUS—Anesthetist; for 50-bed general hospital in northern Maine; two anesthetists employed; liberal vacation and sick leave allowance; salary open; also Operating room nurse, and Obstetrical supervisor; salary open. MO 26, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—General duty; small growing hospital; good pay, part maintenance; paid vacations; pleasant working conditions. Apply, Supervisor of Nurses, Hi-Plains Hospital, Hale Center, Texas.

NURSE—Head; small new hospital, central Illinois; able to handle light surgical program; opportunity to initiate own policies; pleasant working conditions; excellent personnel policies; salary open, depending on ability and experience. MO 20, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Head; in hospital for children with rheumatic fever; excellent salary, good working conditions, maintenance, vacation; near New York City. Apply, Medical Director, Irvington House, Irvington, New York.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

NURSES—General duty; positions open 30 miles from New York City; salary: $210-220 plus 2 meals; 40-hour week, 8-hour day, 3 weeks vacation, 7 paid holidays, 12 days sick leave; also, OPERATING ROOM nurses at higher salaries. Apply, Administrator, Ossining Hospital, Ossining-on-Hudson, New York.

NURSES—General duty; all shifts; 40-hour week; 90-bed general hospital; excellent working conditions; liberal vacations and employee policies; starting salary $264 per month with regular increases; liberal differential for 3-11 and 11-7 shifts; maintenance at nominal charge if desired. Apply, Director of Nursing, East Side General Hospital, 2199 Cadillac Boulevard, Detroit 14, Michigan.

NURSES—General duty; immediate openings; salary $220 per month and complete maintenance; liberal sick leave policy, and two weeks paid vacation after one year. Contact Administrator, Howard County Hospital Foundation, Big Spring, Texas.

NURSES—General duty; new 100-bed hospital; starting salary $260 and up, plus one meal and laundering of uniforms; increase after 6 months; good working conditions. Write, Medical Center Hospital, Odessa, Texas.

NURSES—Two, general duty; 5-day work week; 36-bed hospital; salary $235 per month; 6 paid holidays, 2 weeks paid vacation per year. Gooding County Memorial Hospital, Gooding, Idaho.

NURSES—Graduate; maintenance available; new modern hospital; 3-month increases; elderly patients; 20 minutes traveling from large central Pennsylvania city. MO 34, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Graduate, men; 175-bed, all-man hospital; minimum starting salary $270 per month; 3 weeks' vacation, sick leave, holidays; full maintenance possible; rotating or permanent shifts; 40-hour week; $10 month extra for departments and psychiatry, evening and night shifts; educational bonus; two universities in city; openings in psychiatry and medical departments. Address, Director of Nursing, Alexian Brothers Hospital, St. Louis 18, Missouri.

(Continued on page 218)

classified advertising

POSITIONS OPEN

NURSES—Graduate; for hospital located near beautiful Lake George; salary with complete maintenance; $10 differential afternoon and night duty; 8-hour, 5-day week; time and one-half for overtime. MO 25, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Graduate, registered; for 110-bed general hospital; good salary with full maintenance; private room in beautiful nurses' home; 44-hour week; 2 weeks vacation; 7 paid holidays per year, plus 6 days paid sick leave per year; located 35 miles from New York, served by the DL&W Railroad and the Greyhound Bus Lines. Apply, Dover General Hospital, Dover, New Jersey.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $250 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room and General staff; for staff duty in 125-bed general hospital; good personnel policies; 44-hour week; extra pay for call duty; $10 differential for evening and night duty; maintenance available at minimal cost. For full information, write Director of Nurses, Leominster Hospital, Leominster, Massachusetts.

NURSES—Registered; Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

NURSES—Registered, for supervisory positions and staff nursing for a new and beautifully equipped 100-bed hospital in the Pacific Northwest; excellent salaries and 40-hour week. MO 12, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Registered; for general duty in 70-bed general hospital in San Gabriel Valley, 40 minutes from Los Angeles; close to beaches and mountains; 40-hour week, 2 weeks paid vacation; 6 months increase in salary; paid hospital insurance; starting salary: $235 month; $10 differential for afternoons and nights; $10 differential for surgery and maternity. Write for application form: Superintendent of Nurses, Inter-Community Hospital, Covina, California.

NURSES—Registered; graduate experience in psychiatry desirable, but not essential; newly begun affiliation requires expansion of teaching unit and gives opportunity for rapid advancement; staff salary $225 to $260; social security; 40-hour week; vacation and sick leave; one meal and laundry. Apply, Director of Nursing Service, Utah State Hospital, Provo, Utah.

NURSES—Registered; one for Matron of small hospital in nice country village; mostly maternity, and elderly chronic cases; no special training required; also Registered or Graduate nurse. North Queens Cottage Hospital, Inc., Caledonia, Queens County, Nova Scotia, Canada.

NURSES—Registered, two, supervisory positions; one for evening and night duty relief; also one for 4 P.M. to midnight; 230-bed private psychiatric hospital; $280-$300 monthly; 5-night week, sick leave, vacation, 7 paid holidays. South Oaks, Amityville, Long Island, New York.

NURSES—Registered, two; for 43-bed residential school for cerebral palsied children; program strictly habilitative with all therapies applied to carefully screened patients; new air-conditioned building with modern facilities and equipment throughout; affiliated with the University of Texas Medical Branch; good personnel policies and salary. Apply, Miss Robertine St. James, Director, Moody State School for Cerebral Palsied Children, Galveston, Texas.

(Continued on page 220)

classified advertising

POSITIONS OPEN

NURSES—Staff and Operating room: 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $230 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—General staff: 250-bed general hospital and 72-bed maternity hospital; starting salary $265; $5 per month tenure increase for each six months of service to a maximum of $295; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Staff: three general staff nurses needed for new modern hospital; salary $250-$265; 40-hour week. For full details, write Hoemako Co-operative Hospital, Box 1837, Casa Grande, Arizona.

RESIDENT—225-bed general hospital; adequate opportunities for clinical surgery and medicine; paid 3 weeks vacation; full maintenance; pleasant quarters; salary open. Apply: Administrator, The King's Daughters' Hospital, Portsmouth, Virginia.

PATHOLOGIST—To act as associate of pathologist who is certified, and in charge of department; hospital is also approved for pathological residency; 300-bed capacity; located in central Pennsylvania; new laboratory facilities and very active. Write: D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

SALESMEN—Free lance, or Manufacturers' agents, can sell our very practical items at a substantial profit to themselves; liberal commission on items used in every hospital; if you have the accounts, we have the merchandise. MO 9, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERINTENDENT—Northwestern General Hospital; this 115-bed hospital, in the course of construction on Keele Street, in the township of York, immediately north of Toronto, Ontario, requires the services of a superintendent qualified to perform the duties of superintendent under The Public Hospitals Act and Regulations and also act as business administrator, secretary, have charge of the financial records and assist in the purchasing of equipment required for the new hospital; applicants should state age, experience, qualifications, date available and salary expected. Reply by April 15th, 1953, to Charles E. Webster, 125 Guestville Avenue, Toronto 9, Ontario, Canada.

(Continued on page 222)

SUPERINTENDENT—For hospital in a pleasant, progressive north central Pennsylvania community, population 2700; the hospital has eighteen beds and a staff of eight nurses and six doctors, two of whom are surgeons; give complete resumé and salary expected. Reply to John Kallenborn, 400 Chestnut Street, Port Allegany, Pennsylvania.

SUPERVISOR—Administrative, operating room; large metropolitan hospital with accredited school of nursing and accredited program for surgical residents; nursing and subsidiary staff of 48; 6000 operations in 1952; salary open for candidate qualified by good preparation and broad experience; preferable date June 1 or earlier. Write, Director of Nursing, St. Luke's Hospital, New York 25, New York.

SUPERVISOR—And Clinical instructor for obstetrics; experience and advanced preparation necessary, preferably a degree; for modern, 250-bed hospital, fully approved; 70 miles from New York City; 40-hour week; 3 weeks paid vacation; sick time; hospital care; complete maintenance, if desired, at $45 per month; beginning salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISOR—Obstetrical; 3-11 shift; excellent working conditions with or without complete maintenance; 20-bed addition under construction, to be completed in early spring. Apply, Highland Hospital, Belvidere, Illinois

classified advertising

POSITIONS OPEN

SUPERVISOR—Operating room; full charge; 90-bed general hospital; top salary; 40-hour week; pleasant working conditions with liberal vacations and employee policies; maintenance at nominal charge if desired. Apply, Director of Nursing, East Side General Hospital, 2199 Cadillac Boulevard, Detroit 14, Michigan.

SUPERVISOR—And Clinical instructor for pediatrics; experience and advanced preparation necessary, preferably a degree; for modern 250-bed hospital, fully approved, 70 miles from New York City; 40-hour week; 3 weeks paid vacation; sick time; hospital care; complete maintenance, if desired, at $45 per month; beginning salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISOR—Psychiatric; registered nurse for 230-bed progressive private mental hospital; brain surgery, electro-shock, insulin therapy; 5-day week, 7 paid holidays, 10 days annual sick leave, 4 weeks paid vacation per year; attractive living facilities if desired; salary $280 to start. South Oaks, Amityville, Long Island, New York.

TECHNICIANS—Registered medical laboratory; for new 243-bed general hospital; salary open. Apply: McLaren General Hospital, 401 Ballenger Highway, Flint, Michigan.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Medical; fairly large general hospital; teaching program, fully approved; college town, Pacific coast. (b) Medical; headquarters, national organization; duties include directing educational program, public relations; east. (c) Assistant medical superintendent; large general hospital; substantial salary including 3-bedroom residence; west. (d) Lay; 225-bed general hospital; university city, midwest; $10,000. (e) Lay; to direct two hospitals currently under construction; southwest. (f) Hospital for convalescents and chronic diseases; currently under construction; midwest. (g) Assistant administrator; large teaching hospital; not under 35, minimum five years' experience; university center; east. (h) Assistant; voluntary general hospital, 400 beds; university city, midwest. MH4-1

ADMINISTRATORS—NURSES. (a) General hospital, 125 beds; knowledge of Spanish helpful, not required; staff of American physicians; South America. (b) Hospital for crippled children; expansion program; medical center, midwest; $6500, maintenance. (c) Assistant administrator; large general hospital; vicinity New York City. MH4-2

(Continued on page 224)

MEDICAL SUREAU—Continued

ANESTHETISTS—(a) Chief; large teaching hospital; $5000 including quarters; university medical center. (b) Association, group of anesthesiologists; resort city, southwest. (c) New hospital, foreign operations, American company; $440 plus living allowance, $235. MH4-3

DIETITIANS—(a) Chief and staff dietitians; general hospital, 250 beds, affiliated well known group; university city, Pacific coast. (b) Chief; hospital group affiliated medical school; university city, midwest; $6000, maintenance. (c) Teaching and clinic dietitian; university hospital; university center, south. (d) Assistant dietitian; important hospital; Florida. MH4-4

DIRECTORS OF NURSES—(a) Research and teaching hospital maintaining highest standards of medical and nursing care; 250 students; university medical center, midwest; outstanding opportunity. (b) Voluntary general hospital, 250 beds; fine school, 100 students; university town, east; $6000, maintenance. (c) Voluntary general hospital, fairly large size; considered one of California's leading hospitals. (d) New tuberculosis hospital, unit university group; faculty post; minimum $6000. (e) Nursing service only; fairly large general hospital; Chicago area; $5000-$6500. (f) Nursing service only; general hospital, 175 beds; college town, California. MH4-5

EXECUTIVE HOUSEKEEPER—Voluntary general hospital, 425 beds; university city, midwest; man eligible. MH4-6

As if it were made to your specifications

If you were to write your own specifications for a soap to cleanse a patient's skin thoroughly and comfortably, we believe you'd duplicate very closely the Ivory Soap formula.

For certainly you'd specify a *pure* soap. And no other soap excels Ivory on that score.

You'd insist, too, that your soap be gentle in its cleansing action. And here Ivory would get top rating.

Freedom from strong perfume? Rich lathering and free rinsing qualities? On all of these points, Ivory would meet your specifications.

Yes, Ivory can justly be said to meet the modern hospital's exacting specifications—and its needs. It has been doing just that for well over half a century in countless institutions from coat to coast.

More doctors advise Ivory Soap than any other soap!

Procter & Gamble CINCINNATI, OHIO

99 44/100% pure... it floats

Ivory Soap in the popular unwrapped 3-ounce size (packed weight) is available for hospital use. There are four smaller sizes, too—in wrapped or unwrapped cakes.

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

EXECUTIVE PERSONNEL—(a) Director of purchases; 400-bed general hospital; considerable experience required; east. (b) Personnel director, 600-bed teaching center, expansion program; east. (c) Public relations director experienced fund raising; 300-bed general hospital; midwest. (d) Associate controller; 500-bed teaching hospital; east. (e) Chief admitting officer and credit manager; general hospital, 225 beds, recently opened for operation; expansion later to 450 beds; midwest. (f) Chief accountant and office manager; 300-bed hospital; university center. MH4-7

FACULTY APPOINTMENTS—(a) Assistant professor, public health nursing; Eastern university. (b) Educational director; modern general hospital, 300 beds; suburban town, midwest; $6000. (c) Educational director; collegiate school; Pacific coast; $5000-$6000. (d) Educational director; children's hospital; interesting city, outside United States. (e) Clinical instructor; department of nursing, eastern university. (f) Nursing arts and clinical instructors in surgery and orthopedics; positions carry faculty status; university school; Pacific coast. MH4-8

RECORD LIBRARIANS—(a) Chief, medical record section; new medical center; competent organizer required; $5000-$6500. (b) Chief; 25-man group. Diplomates or eligible; new hospital; university city, west. (c) Chief and two assistants; one of country's leading private practice groups; staff of 60 Board specialists; 350-bed hospital; university medical center. MH4-9

SUPERVISORS—(a) Operating room; to succeed supervisor retiring after tenure of thirty years; 600-bed teaching hospital; eastern metropolis. (b) Pediatric and obstetrical; teaching hospital; Asia. (c) Psychiatric; new department, teaching hospital; university city, south. (d) Surgical supervisor; small hospital; tropical country. (e) Pediatric; beautiful new hospital for children; west. MH4-10

SURGICAL NURSES—(a) Teaching hospital, 600 beds; staff of 300 physicians including residents, interns; expansion program; medical center. (b) To assist two American Board orthopedists; resort city, southwest. MH4-11

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

PATHOLOGIST—To head laboratory in a 200-bed hospital; an unusually fine opportunity.

PHYSICIAN—Group practice, industrial; net income to $18,000.

COLLEGE PHYSICIAN—Male; large school; position carries academic rank of a full professor; salary open—will be good.

DIRECTOR OF NURSING—50-bed hospital; college town; $4200, maintenance.

(Continued on page 226)

MEDICAL PERSONNEL EXCHANGE—*Continued*

DIETITIAN—Chief; 400-bed hospital, eastern Pennsylvania; $4800 plus meals and laundry.

MEDICAL SOCIAL WORKERS—(a) Assistant chief. (b) Home care program; 375-bed hospital; salary open.

RADIOLOGIST—Certified or eligible; to head department; 125-bed hospital; immediate opening; top salary.

Write us for information. Our service is highly confidential.

No charge for registration

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 70-bed new hospital, southern resort area; $6000. (b) 85-bed hospital, small college community, Ohio. (c) 50-bed hospital, Pennsylvania. (d) 45-bed new hospital, Iowa. (e) 275-bed hospital, near university center. (f) 76-bed hospital, eastern city; graduate staff.

ASSISTANT ADMINISTRATORS—(a) 200-bed hospital, Ohio. (b) 150-bed New England hospital.

ACCOUNTANTS—(a) Office manager; 275-bed hospital, Pennsylvania. (b) Large institution, northern Ohio; $450. (c) 300-bed hospital, Connecticut. (d) 125-bed hospital, west.

FOR PROLONGED ANTIBACTERIAL ACTION ON DISINFECTED SURFACES

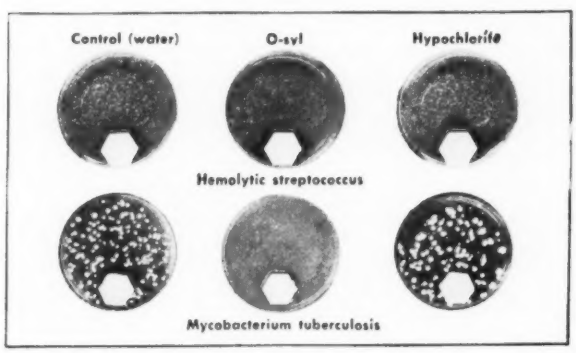
Now — safer, surer procedures are possible in the control of cross infection — without unpleasant disinfectant odor

Proved in hospital use against contagion-spreading germs, including the "secondary invaders" (e.g. M. tuberculosis, Streptococcus pyogenes and others), the nonspecific disinfectant action of O-syl is further enhanced by its *prolonged* antibacterial effectiveness on disinfected surfaces.

Recent scientific tests show that O-syl retains its germ-killing power on surfaces for a *full week*. This contrasts with such disinfecting agents as the hypochlorites whose antibacterial action is dissipated after approximately 1 hour.

Odorless and harmless, O-syl combined with water cleans, disinfects and deodorizes. It can be used with soaps and detergents without loss of effectiveness against bacteria and fungi.

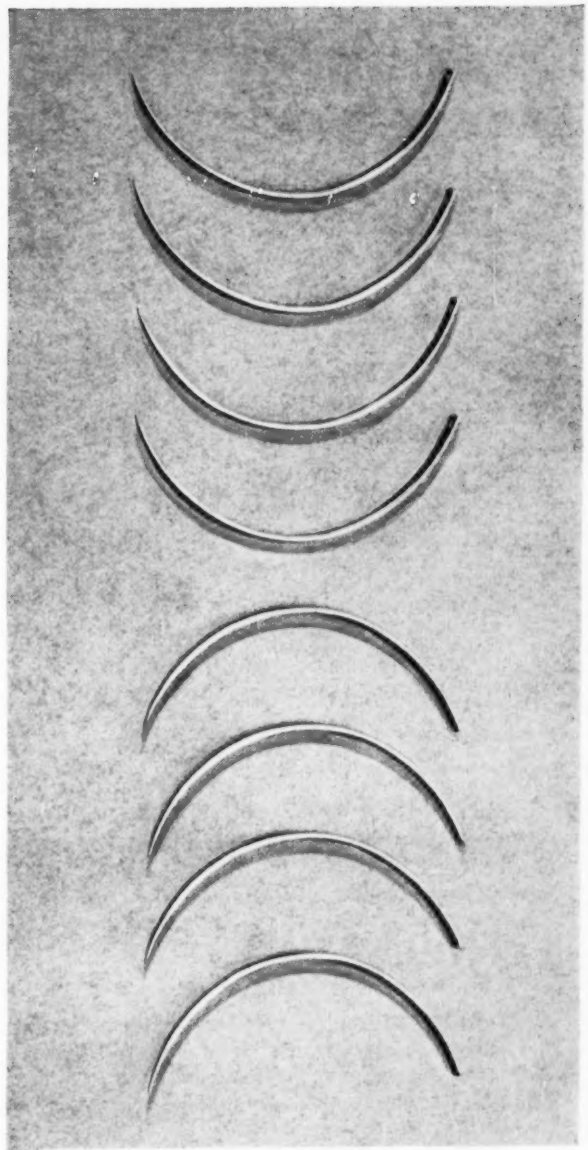
Full information is available to physicians and hospital personnel, free, upon request.



These photographs demonstrate the continuing antibacterial potency of O-syl. Sterilized porcelain hexagons, of the type used in bathroom flooring, were washed with water (left), with O-syl solution (center), and with hypochlorite solution (right). Later the hexagons were contaminated with the bacteria indicated. The antibacterial effect of the hypochlorite solution was no longer in evidence 2 hours after the application. The O-syl solution remained effective for 1 week, at which time the observation was terminated.

O-syl®
Brand Disinfectant

Lehn & Fink Products Corporation, 445 Park Avenue, New York 22, N. Y.
Or your surgical supply dealer



UNIFORMITY IN SIZE AND SHAPE
assured by precise
manufacturing techniques

TORRINGTON stainless steel surgeons needles

Order from your hospital supply dealer. Catalog on request.

THE TORRINGTON COMPANY, Torrington, Conn.
Specialists in Needles since 1866

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POSITIONS OPEN

INTERSTATE—*Continued*

DIRECTORS OF NURSING—(a) 175-bed eastern hospital; $5000, maintenance. (b) 100-bed new hospital; west; graduate nurse staff; $400.

CREDIT MANAGERS—(a) 300-bed hospital, Michigan; $400. (b) 85-bed hospital, North Carolina.

RECORD LIBRARIANS—(a) Chief; 350-bed hospital, east; $350-$400. (b) New hospital, 250 beds; midwest.

EXECUTIVE HOUSEKEEPERS—(a) 200-bed hospital, modern; midwestern university city. (b) Large institution, near Philadelphia; $4200. (c) 250-bed Michigan hospital.

DIETITIANS—(a) 100-bed Massachusetts hospital; $350. (b) 400-bed hospital, Ohio; $5000. (c) Therapeutic; to $350.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

PERSONNEL DIRECTOR—East; 315-bed hospital; approximately 550 employees; fully approved; personnel department was organized in 1952 and preliminary organization has been completed and it is functioning smoothly; position offers challenge to someone who has good ideas on how to expand the department by setting up training programs, employee projects, etc.; will have full cooperation of the Administrator and Board of Trustees; salary will depend upon qualifications but will be better than average.

SHAY—*Continued*

DIETITIANS—(a) Chief; south; 200-bed hospital, city of 35,000; 40 employees in department; $5400. (b) Assistant; east; 500-bed general hospital, over 100 employees in department; $5000. (c) Administrative; east; 275-bed hospital, city of 80,000; $5500. (d) Chief; California; 80-bed hospital in city of about 25,000; no nursing school; $4200. (e) Chief; middle west; 300-bed hospital, city of 50,000; sixty employees in department; $5400. (f) Chief; west; 225-bed hospital, new kitchen and dining room with all modern equipment; employee and patient cafeteria service; $4200. (g) Chief; middle west; 365-bed general hospital, fully approved, located in city of 250,000; hospital affiliated with university if educational advancement is desired; $5500.

HOUSEKEEPERS—(a) Executive; east; 700-bed general teaching hospital; facilities complete and modern. (b) Executive; middle west; 500-bed hospital in city of 275,000; plan to reorganize department; requires someone with good experience. (c) Executive; middle west; 400-bed hospital, fully approved; will have three assistant department heads and supervisors. (d) Executive; southeast; new 70-bed hospital located in very cosmopolitan community; ideal year around climate. (e) Executive; California; 500-bed hospital; plan to reorganize department; requires someone with outstanding ability in training personnel.

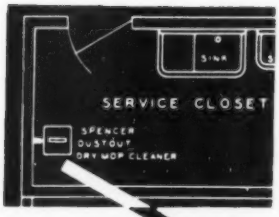
PURCHASING AGENTS—(a) Director of purchases; 500-bed teaching hospital, eastern educational center; must be well qualified. (b) Medium-sized modern hospital, pleasant community adjacent New York City; to $6000.

PHYSICAL THERAPISTS—(a) California; requires someone qualified to handle duties in general hospital which will include arthritic, orthopedic, polio and cerebral palsy cases; $375 to start. (b) East; head active department of 185-bed general hospital; fully approved; $4500. (c) Southwest; 100-bed general hospital located on campus of university; expect to open a new 250-bed teaching hospital in near future; excellent opportunity; $4200 minimum.

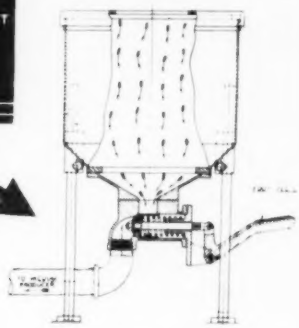
PSYCHOLOGISTS—(a) Middle west; 200-bed institution for care of mental defectives, located in large city; $3660 to start. (b) Middle west; large mental hospital approved by A.M.A. for internships; student psychiatric training and resident training programs; $375. (c) East; large psychiatric hospital located in university town; conduct psychological training of patients, psychotherapy and research; $5100.

PHARMACISTS—(a) Middle west; 160-bed general hospital, fully approved; active department; serve hospital patients only; good salary plus complete maintenance. (b) Middle west; 150-bed general hospital; complete, modern facilities; $400.

(Continued on page 228)



Cabinet 15" square with vacuum slot in cover



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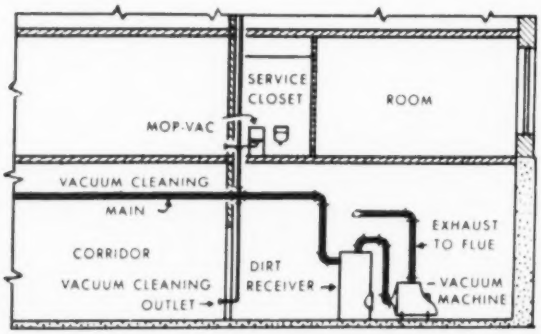
THE SPENCER MOP-VAC

. . . ANYWHERE

The only sanitary way to clean a dry-mop or dust cloth is to let Spencer Vacuum clean it for you. Just pass the mop over a vacuum slot attached to the Spencer System at a baseboard, flush with the floor, or on the top of a cabinet in a service closet. The strands are immediately agitated by the violent rush of air. All dust goes down enclosed pipes to the basement. Fewer steps, more frequent cleaning—and no possibility of germ-laden dust being spread over the hospital.

SIX TYPES Cabinet units are made in the open type illustrated above and in high and low enclosed cabinets. Special attachments are available for baseboard or flush floor mounting and for Spencer Portable Cleaners.



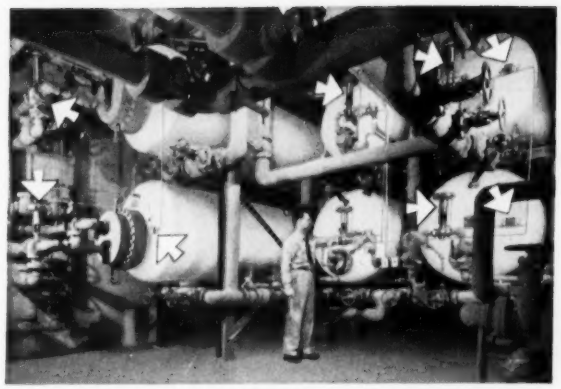
with **SPENCER STATIONARY VACUUM SYSTEM**: The sketch above shows how the Spencer Vacuum producer and dirt separator are located in the basement and connected to vacuum fixtures on all floors for cleaning of floors, bedding, furniture and equipment of all kinds.

The Spencer Mop-Vac is described in Bulletin No. 138-C and the Stationary System in Bulletin No. 33.

THE SPENCER TURBINE COMPANY • HARTFORD 6, CONNECTICUT

SPENCER HARTFORD

450 C



Water Heaters Controlled by Powers Accritem Regulators

What's Your Water Temperature Control Problem?

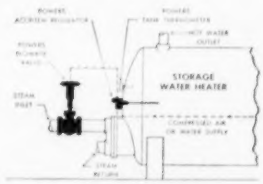
POWERS . . . with their many types of thermostatic regulators and 60 years experience is well qualified to help you find the right type of control for these applications:

Forced Hot Water Heating Systems; various types of Water Heaters and Heat Exchangers; Jacket Water Cooling for Air Compressors, Diesel and Gas Engines also Cyclotrons, Chocolate Enrobers and Plastic forming Presses; all types of Shower Baths and Hospital Hydrotherapy; processing X-Ray, Regular and Colored Film — and hundreds of other uses.

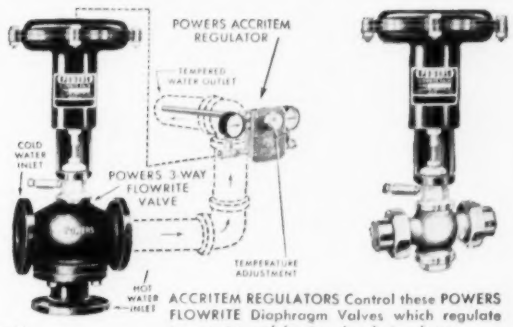
Only one of Powers varied line of water temperature controls is shown here . . . the *Accritem Regulator*. It's compressed air operated, has calibrated dial temperature adjustment, adjustable sensitivity and many other features described in *Condensed Catalog 3035*.

Compressed Air Operated

Only one of many applications Small Size. Bulb is 12" long



Powers Accritem Regulators Give Years Of Dependable Service



(a92) ACCRITEM REGULATORS Control these POWERS FLOWRITE Diaphragm Valves which regulate temperature of heaters in photo above.

THE POWERS REGULATOR COMPANY

Skokie, Ill. • Offices in Over 50 Cities, see your phone book.

OVER 60 YEARS OF WATER TEMPERATURE CONTROL

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POSITIONS OPEN

OUR 57 th YEAR

WOODWARD
Medical Personnel Bureau
FORMERLY AZNOES
3rd floor • 185 N. WABASH AVE.
CHICAGO • 1
• ANN WOODWARD • *Director*

If None of These Opportunities Meets Your Requirements, Please Ask for an Analysis Form So We May Prepare an Individual Survey for You.

Strictly Confidential

ADMINISTRATORS—(a) Medical; direct educational program; general hospital, 550 beds; medical school affiliation; $12-$15,000; university city, 200,000; northeast. (d) Lay; general hospital; 425 beds; south. (e) Medical; to relieve present director during military absence; every possibility of permanent association; large university hospital. (g) Lay or medical; general hospital, 180 beds; expansion program; west.

WOODWARD—*Continued*

ADMINISTRATIVE STAFF APPOINTMENTS—(b) Personnel supervisor; very large hospital; southeast. (d) Business manager; group of minimum 8 to 10 hospitals; 50 to 200 beds; within radius 100 miles; currently under construction; able organizer required. (f) Accountant; voluntary general hospital, 120 beds; very cooperative staff; opportunity advancement to assistant administrator; one of nicest hospitals in Chicago area; requires at least 3 years experience in hospital accounting; minimum $5000.

DIRECTOR OF NURSES—(aa) Young, well-experienced; voluntary general hospital, 100 beds; although no school, must have degree; very cooperative staff; one of nicest hospitals in Chicago area; $6000 plus full maintenance including lovely apartment. (a) Voluntary general hospital, 300 beds; 70 students; excellent medical staff; majority certified; one of finest west-coast hospitals; minimum $6000. (d) Nursing service only; large teaching hospital; faculty appointment; midwest. (e) General hospital, 300 beds; accredited school; Atlantic seaboard near New York City; excellent salary, full maintenance. (f) Voluntary general hospital, 350 beds; excellent training program; $5-$6000; east. (g) Assistant director nursing education; voluntary general hospital; 200 beds; 80 students; $350-$500; east.

(Continued on page 230)

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

11 West 42 Street New York 36, N. Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

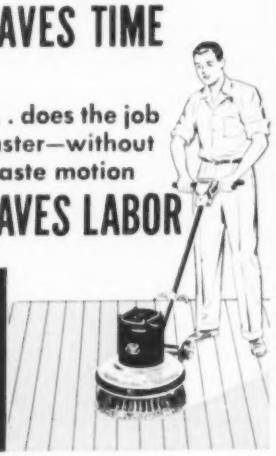
For floor finishing or daily maintenance, Brillo solid-disc steel wool floor pad hardens and brightens finish. Regular once-over removes traffic grime—renews gloss quickly without rewaxing. Equally efficient for linoleum, asphalt or rubber tile, wood, and terrazzo.

* * *

For free folder on low-cost Brillo floor care, write to Brillo Mfg. Co., Dept. M, 60 John St., Brooklyn 1, N. Y.

. . . BRILLO cleans and buffs in one operation
SAVES TIME

. . . does the job faster—without waste motion
SAVES LABOR



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SOLID-DISC STEEL WOOL
FLOOR PADS

THE AMERICAN APPRAISAL COMPANY

Valuation of Tangible and Intangible Properties for Insurance Accounting Finance Tax and Legal Requirements

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PLACEMENT BUREAUS

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Doctors Building
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Opportunities in most areas for Medical Directors, Administrators, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Technicians, Therapists, Librarians and all areas of Supervisory hospital personnel.

FRANCES SHORTT MEDICAL AGENCY
SPECIALISTS in the Placement of Competent Medical and Social Service Personnel.
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BROWN'S MEDICAL BUREAU (Agency)
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If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

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ZINSER PERSONNEL SERVICE
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We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

CALIFORNIA AND WEST COAST
Complete Coverage
Hospitals—Clinics
Excellent Openings—Confidential Services

CONTINENTAL MEDICAL BUREAU, Agency
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Agency
703 Market Street, San Francisco 3

(Continued on page 232)

MISCELLANEOUS

HENRY G. FARISH, M.D.
MEDICAL AUDITS FOR HOSPITALS
Sunbury, Pa. R.D. No. 2

DISTRICT SALES SUPERVISOR

For well established manufacturer of hospital furniture. Successful applicant must have extensive background in hospital field and good hospital following. Reply must include full particulars concerning age, education, experience, family status and income expected. All replies will be held fully confidential. MO 33, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

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400 East 59th Street, New York City

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FOR SALE

For Sale: Used surgical operating tables, obstetrical tables and bassinets.
METHODIST HOSPITAL
Peoria, Illinois

NURSING AND MEDICINE
We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS
Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

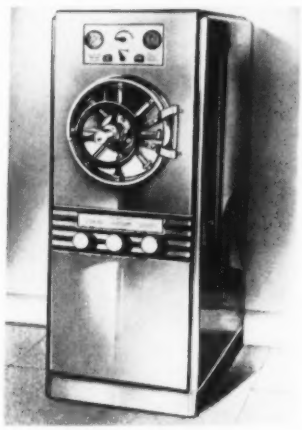
Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

What's New for Hospitals

APRIL 1953 — Edited by BESSIE COVERT

To HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 248. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Instrument Washer-Sterilizer



The new Ohio instrument washer-sterilizer soaks, scrubs, sterilizes, drains and dries instruments in 17 minutes. The operation is automatic throughout, requiring only two dial settings. The unit operates with direct steam heat and the automatic control circuit operates on 115 volt, 60 cycle A.C. An automatic electric lock prevents opening the door if any water remains in the chamber and a steam-lock mechanism prevents opening the door when there is any pressure in the chamber. A visual light signal indicates that the unit is in operation and a second visual light signal informs the operator when the door may be opened.

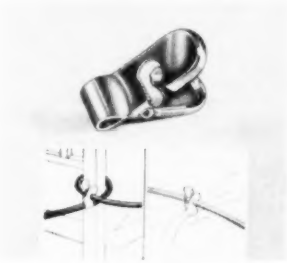
The washer automatically heats water under pressure to a temperature of 270 degrees, violently scrubbing the instruments. The dirst washes away over a knife-edge rear overflow. Two trays are supplied for the monel metal sterilizing chamber which has a capacity of approximately 1100 cubic inches. When the sterilization cycle is completed, the water is automatically drained off and the chamber is heated intermittently to dry the instruments. An audible alarm signals when all pressure and water have been ejected. The dual-purpose unit can also be used as a conventional, manually operated high-speed instrument sterilizer. It can be installed exposed or recessed. **Ohio Chemical & Surgical Equipment Co., Dept. MH, 1400 E. Washington Ave., Madison 10, Wis. (Key No. 713)**

Vacuum Pump

Eight models of the new NCG vacuum pump for central suction systems provide service for areas from five to 150 rooms. The pump is an oil-seated rotary type with blades that compensate for their own wear. Equipped with an automatic on-and-off control, automatic lubricator, vacuum line filter, drive motor, magnetic starter and vacuum gauge, the pump occupies a minimum of floor area as all components are located above the vacuum tank. **National Cylinder Gas Co., Dept. MH, 840 N. Michigan Ave., Chicago 11. (Key No. 714)**

Bell Cord and Tubing Holder

An effective yet simple bell cord holder has been developed which is equally useful as an intravenous tubing holder. Consisting of a small clamp



with jaws actuated by a strong spring, the holder grasps bedding between its teeth. The serrated teeth are rounded to prevent damage to bed linens. Two wings with opposing slots carry tubing or cord. Made of non-corroding materials, the clamp measures only 1⅝ by ¾ inches and will carry cord or tubing up to 5/16 inch in diameter. **A. S. Aloe Co., Dept. MH, 1831 Olive St., St. Louis 3, Mo. (Key No. 715)**

Plasticon Sheeting

Plasticon is a durable, lightweight plastic material which remains smooth, soft and pliable even after repeated washings. Plasticon sheeting can be sterilized, autoclaved and washed with mild soaps or detergents. Because the plasticizer is locked in, the sheeting does not become sticky. The new sheeting is crease resistant, wrinkle resistant and stain resistant. It does not support combustion and is non-toxic. Water, oil and grease do not affect the sheeting and it can be kept wiped clean with a damp cloth, or washed. The material is easy to cut and handle and is easily folded for storage.

A new mattress protector of Plasticon is now available. It is tailored to fit and slips over any mattress, regardless of thickness. Plasticon is available in opaque white and can be had in 25, 50 and 100 yard rolls in 36 and 48 inch widths for all hospital requirements. **Continental Hospital Service, Inc., Dept. MH, 18624 Detroit Ave., Cleveland 7, Ohio. (Key No. 716)**

Pictura Furniture Group

Pictura is a new styling in Simmons steel furniture especially developed for hospital rooms. Pieces include beds, dressers, bedside cabinets with Zalmite tops, desk, chest, Van-D-Dresser and matching chairs. The lines of the new styling are smooth, with drawers opening without pulls. Roomy recesses beneath each drawer front permit easy opening. Cleaning and dusting are easier and quicker with the absence of pulls and other protrusions on the face of the cabinets.

Cases in the Pictura styling are available with steel tops or with the added protection of self-banded Zalmite tops that resist burning, scratching, alcohol and marring. The Pictura line is avail-

able in all Simmons colors and grain finishes. **Simmons Company, Dept. MH, Merchandise Mart, Chicago 54. (Key No. 717)**

(Continued on page 236)

What's New . . .

Bed End and Spring

The new Foster No. 4451 Bed End and RDX Spring have been developed to meet the need for attractive, comfortable sleeping facilities for nurses' homes and interns' and doctors' living quarters. The unit offers a stylized low height modern design suitable for a Hollywood Bed. The spring section has three rows of permanently attached coil springs to prevent center sag and to assure comfortable, restful sleep. A rigid foot bar prevents the mattress from slipping. Head ends are available in a wide variety of stock wood grain and enamel finishes, or they can be color-matched to harmonize with any decorative arrangement on special order. **Foster Bros. Mfg. Co., Dept. MH, 811 Broad St., Utica, N. Y. (Key No. 718)**

Waste Disposer

A new grinding principle has been incorporated into the Herlex Food Waste Disposer resulting in exceptional fineness of grind for ready flushing of waste down the drain, thus eliminating food waste in seconds, as it occurs. The Herlex is engineered for rigorous heavy-duty operation but is compact in size and easily installed. It is constructed of non-corrosive aluminum alloy, powered by a heavy-duty 5 h.p. motor and has the inlet adapted for conveyor, funnel or other arrangement required. **Herlex Mfg. Co., Dept. MH, 1442 W. Van Buren St., Chicago 7. (Key No. 719)**

Floor Tile

Robbins Lifetime Vinyl All-Purpose Terra-Tile is a new floor covering which can be installed without the use of adhesives. The back of the vinyl tile is honeycombed, making the tile more resilient and twice the thickness of conventional tile. The pockets formed by the honeycomb construction exert a suction cup effect that helps hold the tiles in place, prevents moisture seepage between the joints and traps air which insulates against temperature extremes.

A special cutting and squaring process achieves accuracy and uniformity in the tile. Dimensional stability prevents expansion or contraction after installation. The tile can be removed and installed in new locations or in different designs. It is available in 16 terrazzo patterns. **Robbins Floor Products, Inc., Dept. MH, Tuscumbia, Ala. (Key No. 720)**

Reach-In Refrigerator

A new medium sized, medium priced reach-in refrigerator is now being introduced as the Jordon Model S-40. It is cooled by the Jord-O-Matic High-Humidity Blower Coil which is ceiling mounted and out of the food storage area. It is available with either seven heavy duty wire shelves or with four shelves and two rows of meat hooks.

Powered by a ⅓ h.p. sealed compressor with adjustable temperature control, no special installation or wiring is necessary as the unit operates by plugging into any standard electrical outlet. It is of heavy gauge steel with aluminum interior. **Jordan Refrigerator Co., Inc., Dept. MH, 58th and Grays Ave., Philadelphia 43, Pa. (Key No. 721)**

Model WD-15 Vacuum Cleaner

A two-stage turbine, powered by a ⅞ h.p. universal type motor, both moisture proof and rubber mounted, picks up water, dirt and dust quickly and thoroughly in the new Model WD-15 wet-dry vacuum cleaner. The unit is easily portable with four free-running,

ball-bearing swivel rubber casters. The water lift is 61 inches. The 8½ gallon tank of heavy gauge steel is reenforced for strength and interior and exterior are porcelain to prevent rust and corrosion. When the tank is filled to capacity, a newly developed positive action shut-off takes effect. A protective non-marking rubber surrounds the base of the machine. **Clarke Sanding Machine Co., Dept. MH, Muskegon, Mich. (Key No. 722)**

Aluminum Fry Pans

Two new commercial aluminum cookware fry pans have been added to the Stahl line of aluminum cookware. The pans come in two sizes, 8 and 10 inches, and feature malleable steel handles for coolness. The rounded corners make them easier to clean and they have greater thickness at rim and corner for extra long wear and extra bottom thickness for even distribution of heat. **Harlow C. Stahl Co., Dept. MH, 1375 E. Jefferson Ave., Detroit 7, Mich. (Key No. 723)**

(Continued on page 238)

Food Checking Machine and Register

Space and time are saved at the cashier's desk of the cafeteria with the new National Class 21 machine for checking food. Both patron and institution are protected since the machine makes visible the price charged for each item, tax and total, as recorded on the machine. All amounts are mechanically added and the total on each ticket added into the locked-in total within the machine.

The machine features quiet and smooth operation, easily depressed keys, automatic total bar and large legible figures on both the indication and the patron's ticket. The machine is available with or without a cash drawer. It is equipped with automatic counters which show the number of customers served, number of times tax was charged, number of times the No Sale key was used and how often the total was cleared out of the machine. **National Cash Register Co., Dept. MH, Dayton, Ohio. (Key No. 724)**

Mobile Clinic

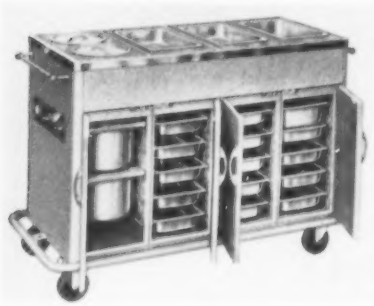
A completely-equipped bus has been built by the Flxible Company to house a mobile clinic for patients in the rural area of Watertown, South Dakota. The bus has been built to include complete toilet facilities, shower bath and thermostatically-regulated hot and cold running water. There are numerous electrical outlets for the attachment of sterilizers, clocks, radios, television set, electric blankets, stove, refrigerator and air conditioning system, and other electrical equipment. Electric current is provided by a portable 5000 KVA generator.

The Roamer III was developed for Dr. H. J. Bartron of the Bartron Hospital and Clinic and is mounted on a standard Flxible Land Cruiser chassis and powered by a Buick FB-320 engine. In addition to rooms and facilities for caring for patients, the bus has road sanders and special air wrenches and adapters to operate from the airbrake

system. The compartment for the driver is completely separate from the rest of the coach. **The Flxible Company, Dept. MH, Loudonville, Ohio. Key No. 725)**

What's New . . .

Portable Food Cart



A complete meal, including salad, soup, entree, vegetable and dessert, may be served from the new Naco Portable Electric Food Cart. Hot meals stay hot in the insulated "hot" compartments and cold foods stay fresh and palatable in the refrigerated compartment. The cart is loaded and then is plugged into any convenient outlet when the cart reaches the serving area, keeping the hot food hot until served. Each cart holds 18 serving pans in the hot section and six pans in the cold section.

The cart has sectional heat regulators for greater heat efficiency. It is easy to clean and can be washed or steam cleaned in a minimum of time. In transit the insulated cover is placed on top of the cart which is easily moved by one person. **National Cornice Works, Food Service Div., Dept. MH, 1323 Channing St., Los Angeles 21, Calif. (Key No. 726)**

Shallow Surface Luminaire

Designed for use with a variety of slimline and standard fluorescent lamps, the new Type SC shallow surface Westinghouse luminaire is only 3 5/16 inches deep. It is available in 4, 6 or 8 foot lengths and two and four lamp widths. It is ideal for low ceiling areas as well as in higher ceiling areas where a shallow suspended system will add to the attractiveness of the room. The unit may be mounted in rows or individually. Translucent side panels eliminate sharp contrast and the hinge down louvers provide 35 degree shielding. Installation and maintenance are simplified by the design of the luminaire. **Westinghouse Electric Corp., Dept. MH, P. O. Box 2099, Pittsburgh 30, Pa. (Key No. 727)**

Cellulose Napkins

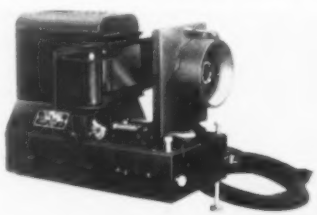
The new Snow-Soft Servaides are three-ply cellulose napkins for institutional use. The napkin looks, acts and feels almost like linen, is lint-free and may be imprinted if desired. A wet napkin has no tendency to break or shred. **Erving Paper Mills, Dept. MH, Erving, Mass. (Key No. 728)**

"Cubelet" Ice Maker

Small ice "cubelets," 5/8 inch in size, are made in the new Frigidaire ice making machine. The small size makes the ice cool faster for beverages while lasting longer than crushed or chipped ice. Also the small size is suitable for packs and similar uses.

The new ice maker is similar in design and construction to the Frigidaire machines making the larger sized cubes except for the cutting grid. Thickness of the cubelets can be adjusted to meet individual requirements. The stainless steel storage bin holds approximately 10,000 cubelets and the machine makes approximately 200 pounds or 20,000 cubelets per day. The machine operates automatically, is powered by a Frigidaire Meter-Miser rotary compressor, and the temperature in the storage compartment is such that cubelets do not sick together. The compact, all-steel cabinet is counter height and the top can be used as a working surface. **Frigidaire Division, General Motors Corp., Dept. MH, Dayton 1, Ohio. (Key No. 729)**

X-Ray and Microfilm Projector



The new Model "70" Projector has been developed to permit the showing of 70 mm copies of large x-ray plates and large drawings containing exceptional details. The new projector permits the enlargement of copies to their original dimensions or larger. Excellent screen images are assured with the 300 watt, 115 volt, T-10 projection lamp and condensing system. Forced air draft keeps lamp, condensers, heat absorber and slide cool, and black film can be safely exposed indefinitely.

Provided with elevating legs to aid in securing good screen performance, the projector is equipped with either a 127 mm or a 135 mm focal-length objective, both of which are fully achromatic and coated for low reflectance-loss. Focusing is accurately controlled by rack and pinion. Two slide carriers are provided and separate frames are fed into the projector in a pair of individual framing kits, either horizontally or vertically. For frames kept on continuous strips, a feed-through mechanism permits the rolled film to be carried either forward or backward. **Charles Beseler Co., Dept. MH, 60 Badger Ave., Newark 8, N. J. (Key No. 730)**

(Continued on page 240)

"Space Saver" Dishwasher

A compact, single tank, door type dishwasher is offered for kitchens with limited space. The HD and HDC dishwashing machines give fast, thorough and complete dishwashing operation. They are modern in design and can be equipped with all time-saving controls to meet health department requirements. Two counter-balanced doors provide for either direction of feed for straight through operation or for a corner installation. All controls are conveniently mounted for either type of operation. **Universal Dishwashing Machinery Co., Dept. MH, 50 Windsor Place, Nutley 10, N.J. (Key No. 731)**

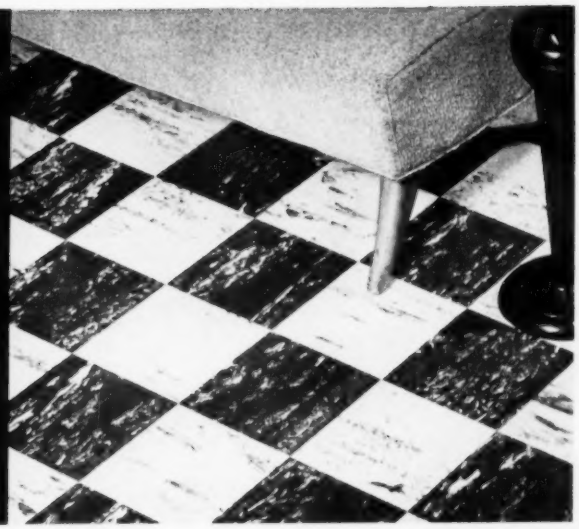
Linen and Uniform Hamper

Care of soiled uniforms for nurses, interns and other personnel in nurses' homes and other residential quarters can be simplified by use of the KleenHamper. This container can be set up in any desired location, indoors or out, either fastened down or left free to be moved, and uniforms and other garments to be laundered or cleaned can be deposited at any hour.

Sturdily constructed of steel, the KleenHamper has a top door which opens into a writing space for bags, tickets and pencils to mark the soiled linen properly. It is constructed to prevent pilfering. The clothing chamber will hold approximately 80 pounds of soiled linens and cannot be entered without a key. The Magic Eye on the front panel lights when linens are deposited. The KleenHamper is 30 inches wide, 27 inches deep and 62 inches high. The unit is finished in white or green hamerloid. Use of the KleenHamper protects uniforms, allows more careful identification and return to the proper person and permits collection

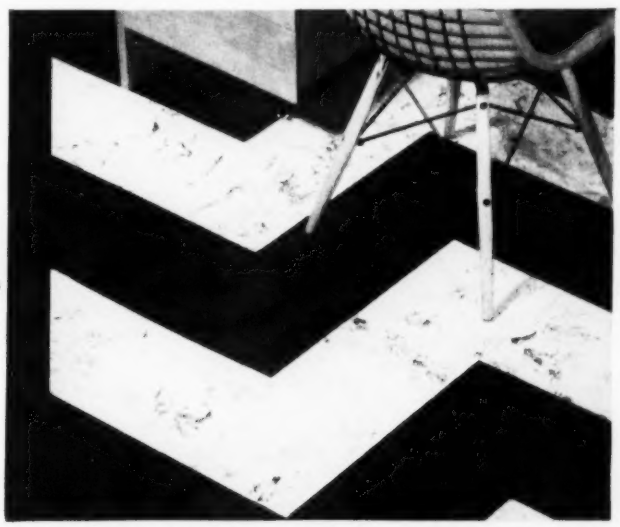
of soiled uniforms and linens in one place for quick and easy pickup. **KleenHamper, Inc., Dept. MH, Greenville, Ill. (Key No. 732)**

GOLD SEAL ASPHALT TILE—23 handsome colors in ⅛", true-cut 9" x 9" tiles. Here is a quality, low cost, durable material for use over concrete floors, on and below grade. Ideal for commercial and institutional installations where low initial cost is a primary factor.



GOLD SEAL RUBBER TILE—20 high-fashion colors in ⅛" rubber tile. Great natural resilience for comfort underfoot. Tremendous durability. Skid-resistant, quiet, clean, easy to maintain. Perfect for hotels, hospitals, churches, restaurants, and smart shops.

HOW TO SAVE MONEY with GOLD SEAL Floors!



GOLD SEAL NAIRN LINOLEUM—Genuine ¼" burlap back inlaid linoleum . . . in both yard goods and 9" x 9" tile. 34 patterns in Veltone, Plain, and Jaspe afford a wide variety of decorative floor treatments. Recommended for stores, offices, banks, public buildings . . . and wherever true resilience, long wear, and easy maintenance are desired.

Real economy lies in careful choice of material that best suits all your particular requirements

Want to solve your floor covering problem simply? Sensibly? *Economically?* Get the expert advice of the organization whose successful experience covers the *entire* field of resilient flooring . . . Congoleum-Nairn Inc.

Each one of the many types of Gold Seal Floors has been scientifically developed over the years to meet specific, *different* needs . . . manufactured to meet them squarely and *economically*. The famous Gold Seal *money-back guarantee of satisfaction* covers the entire line . . . serves as proof of their superlative quality. Three types of Gold Seal Floors are shown here.

No matter how tough *your* problem . . . how tight your budget . . . the best step you can take is to consult Congoleum-Nairn. Write Customer Service Department for *straight* answers leading to the one right solution.

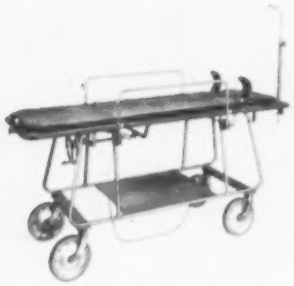
Colorful, informative booklet available free.

GOLD SEAL® FLOORS AND WALLS

CONGOLEUM-NAIRN INC., Kearny, N. J. © 1953

What's New . . .

Tomac Wheel Stretcher



The frame construction and wide wheel spread of the Tomac Wheel Stretcher have been designed to make it virtually impossible to tip. The all welded steel body has a removable litter and a special platform attached to the lower frame gives ample space for blankets and other supplies. Two wheel brakes are located diagonally opposite each other on the carriage and the stretcher rolls straight without a locking device. The stretcher is finished in gray Surgalum and is 26½ inches wide, 78 inches long and 34½ inches high. Optional attachments include Trendelenburg lift, shoulder braces, side rails, intravenous standard, and airfoam pad for litter and shoulder braces. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 733)**

China Patterns

Two new patterns have been introduced in Walker China. An attractive, solid green rim decorates the "Narrim" shape to produce the Greendale pattern. This is a simple, neat pattern in moderately priced china. The second new pattern, Poplar, is available in rich shades of any standard color. It is an attractive leaf design in a hand-engraved pattern. **Walker China Co., Dept. MH, Bedford, Ohio. (Key No. 734)**

Stand-By Electric Plant

Engineered primarily for emergency stand-by service, the new Universal electric generating plant has a 10 KW capacity suiting it for a wide range of applications. It is available with electric starting or can be supplied with controls which automatically start the plant when regular power fails. The four cylinder air cooled gasoline engine is a feature of the new model. Maintenance needs are reduced to a minimum and the modern design of the plant makes it a compact unit saving on installation space. It can be furnished for single phase or three phase service, at either standard or special voltages, and provides a combination of low initial and operating cost. **Universal Motor Co., Dept. MH, 494 Universal Drive, Oshkosh, Wis. (Key No. 735)**

Medicone Series on Public Health Nursing

A new series of 193 2 by 2 inch 35 mm. Kodachrome photographs on public health nursing is now available. Made under the supervision of the Visiting Nurse Association of Brooklyn, the series shows the various activities of the Public Health Nurse, including administrative practices, nursing services, physical therapy service, day care centers and other phases. A teaching syllabus is available with the slides. **Clay-Adams Co., Inc., Dept. MH, 141 E. 25th St., New York 10. (Key No. 736)**

Rotary Snow Plow

The improved Sno-Master is a powerful rotary screw type snow plow which is easy to operate and facilitates the removal of large quantities of snow. The chain equipped wheels are power driven, thus giving the machine the traction necessary to remove up to two feet of snow with minimum effort on the part of the operator. The rotating screw

forces snow into revolving steel blades which throw it to the side. The deflector is adjustable to right or left and to control distribution as the force is sufficient to throw the snow 25 feet.

Operating mechanism in the Sno-Master is protected against snow damage and the machine is engineered for many years of efficient service with minimum maintenance. **The Bready Tractor and Implement Co., Dept. MH, 212 Aurora Road, Solon, Ohio. (Key No. 737)**

Plastic Brite Kit

Stains are quickly and easily removed from plastic dishes with the new Plastic Brite Kit material. Dishes are soaked for one minute in each of two solutions prepared by dissolving one ounce of the powdered materials in one gallon of water. Chemicals used are harmless to skin and to plastics, yet remove even stubborn stains. The kit is inexpensive. **Kelite Products, Inc., Dept. MH, 1250 N. Main St., Los Angeles 12, Calif. (Key No. 738)**

(Continued on page 242)

Improved Electron Microscope

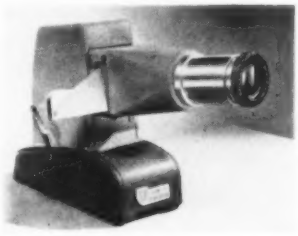
An improved table microscope, Type EMT-3, has been introduced which permits more simplified operation. An external alignment for the pole piece and a new type of vacuum gauge allow precise alignment of the specimen in the instrument and provide a positive indication when the equipment is ready for operation. An improved version of the Universal model electron microscope, Type EMU-2D is also available. It is capable of selected area diffraction as well as producing the usual transmission-type diffraction patterns. Also available is an EMV-6 shadow-caster, used to prepare shadowcast microscope specimens to enhance contrast and bring out third-dimensional effects.

Also introduced recently is a new multiple-exposure film holder which makes it possible to record 20 micrographs on 35 mm. film in an electron microscope without breaking the vacuum. The new attachment for the Type EMT table model is designed for making wider area micrographs. **RCA Victor Div., Radio Corporation of America, Dept. MH, Camden, N. J. (Key No. 739)**

Reviewer 500 Projector

An addition to the line of American Optical Company still projectors has been announced in the Reviewer 500. The new blower-cooled, 500 watt projector is designed for use with 2¼ by 2¾ inch slides but can be converted for use with 2 by 2 inch slides. It is a compact, portable unit giving high quality projection with precision optics. The silent motor-driven blower cools the lamp house as well as the slide and the condensing elements. Slides are not damaged no matter how long they may be left in the projector. Screen image of maximum brilliance from edge to edge is assured by the 500 watt bulb and four element condensing system.

The projector is attractively styled and finished in two tone baked enamel. The newly designed metal slide changer has AO patented Auto-focus which automatically centers the slide in the optical path. An accessory 2 by 2 inch slide



changer with adapter, and lift-off, leatherette-covered carrying case are also available. **American Optical Co., Dept. MH, Southbridge, Mass. (Key No. 740)**

What's New . . .

Stainless Steel Tables

Lakeside Stainless Steel Utility Tables are now available in two sizes for instru-

ments, dressings, medicines and other items. The tables are ruggedly constructed of all stainless steel and are easy to keep clean and bright with a minimum of maintenance. The tables are made 15½ by 24 inches and 17¾ by 27 inches in size with two shelves. **Lakeside Mfg. Co., Dept. MH, 1979 S. Allis St., Milwaukee 7, Wis. (Key No. 741)**

Floor Tester Kit

Checking the conductivity of floors and other equipment in rooms with inflammable gases can be done with the new Midget Megger Floor Tester Kit. It is simple to measure accurately the conductivity of floors and other equipment in anesthetizing areas in the operating room. The unit complies with the National Fire Protection Association's "Recommended Safe Practice for Hospital Operating Rooms," according to the manufacturer. **James G. Biddle Co., Dept. MH, 1316 Arch St., Philadelphia 7, Pa. (Key No. 742)**

"Jet Flow" Sink

Designed for fountain use, the new Jet Flow Sink reduces the possibility of glass and dish breakage since the Jet Flow principle feeds water to any one of three basins by means of a short, soft-flow faucet. The basins are one piece, deep drawn stainless steel with no seams or crevices, thus facilitating cleaning and improving sanitation. The front facing, top capping and rear splash are one integral unit formed from a single piece of heavy stainless steel.

The sink also features the new removable grid drainer which assures positive draining and eliminates possibility of contamination from standing water. **Liquid Carbonic Corp., Dept. MH, 3100 S. Kedzie Ave., Chicago 23. (Key No. 743)**

Fenestra-Nepco Electrifloor

A new electrified steel panel subfloor has been developed by Detroit Steel Products Company and the National Electric Products Corporation. It is of cellular, light-gauge steel construction and has a header duct system with conductors running through the cells of the floor which permits the installation of electrical outlets in each square foot of space. The cellular panels are of steel and the method of construction saves material in the panels as well as in floor construction. The unit panels can be welded together in any desired combination. The floor has been tested by Underwriters' Laboratories and has received the listing and approval of this organization, according to the manufacturers, as well as being certified by the National Building Code and building codes of major cities in the United States. **Detroit Steel Products Co., Dept. MH, 2250 E. Grand Blvd., Detroit 11, Mich. (Key No. 744)**

Rubber-Cushion Furniture Glides

A rubber-cushion furniture glide with a stainless steel base has recently been introduced. The freedom from rusting offered by stainless steel eliminates the possibility of rust stains on floors and

rugs. The base is broad and flat, giving a wide area of flat contact with the floor surface. The rubber-cushion attached to the metal base rests under the furniture leg when the glide is installed, thus cushioning the weight and making moving easier and quieter. The glides are available with attaching devices for all types of wood and metal furniture. **The Bassick Co., Dept. MH, Bridgeport 2, Conn. (Key No. 745)**

Automatic Aerator

The new Cory Automatic Aerator-Mixer is designed to provide a practical and simple method for properly and instantaneously re-hydrating food concentrates such as frozen juices, soups and the like. The concentrate is put into the mixer chamber and, at a touch of the button, it is automatically mixed with a measured amount of water, either cold or hot, and thoroughly and automatically aerated for six seconds. The mixer stops automatically. **Cory Corporation, Dept. MH, 221 N. La Salle St., Chicago 1, (Key No. 746)**

(Continued on page 244)

Infant Size Welsh Electrode

Designed to be used both as a chest and limb electrode, the new Welsh Electrode, Infant Size, has a circular opening in the cup 1½ centimeters in diameter. The cup is made of nickel silver and may be used as a chest electrode in conjunction with flat limb electrodes. The electrode will adhere firmly and comfortably to the skin when the bulb is compressed, the cup applied to the prepared skin and the bulb released. The need for an assistant is eliminated and the work of the operator speeded. **Bowen & Co., Inc., Dept. MH, 4706 Bethesda Ave., Bethesda 14, Md. (Key No. 747)**

Automatic Sink Dishwasher

Fearless Automatic Sinks provide a low cost mechanical dishwasher for institutions serving up to 200 meals. The dishwashers require no booster heater and the dishes dry without toweling. Dishes are placed in the basket and then into the wash compartment. The detergent water is strongly agitated and recirculated by the pump, washing all dishes and utensils. Then the basket is dipped into the 180 degree rinse water. **Fearless Dishwasher Co., Inc., Dept. MH, 175 Colvin St., Rochester 2, N. Y. (Key No. 748)**

Waste Bag Holder

A simple heavy wire holder has been developed which serves a double purpose. Waste bags are firmly held without the use of safety pins, yet are easily put in place and removed. Space on the side of the holder is made to fit tissue packages, thus making tissues readily available without taking up space on the bed or bedside table. The patented lock ring is designed to hold a standard number eight Kraft bag in rigid position with full disposal opening. It protects the bag from tearing and permits ready removal. The holder fits all standard bed rails, is installed without the use of tools and

need not be removed when linens are changed on the bed. **Kad-Ette Products Co., Dept. MH, 1360 W. Touhy Ave., Chicago 26. (Key No. 749)**

What's New . . .

Pharmaceuticals

Distrycin

Distrycin is a new effective streptomycin preparation combining equal parts of streptomycin sulfate and dihydrostreptomycin sulfate. The use of only half as much of each drug in a combination dosage reduces toxity appreciably. Distrycin is indicated in all conditions in which streptomycin or dihydrostreptomycin are prescribed. It is supplied in 1 Gm and 5 Gm vials. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 750)**

Suspension Neolin

Suspension Neolin provides a ready to use aqueous preparation of penicillin which is stable at ordinary room temperature for periods up to 24 months. Suspension Sulfa-Neolin provides in a single preparation a combination of triple sulfonamides and a stable aqueous suspension of penicillin. The indications for Neolin are generally infections susceptible to penicillin, those for Sulfa-Neolin are for those infections more sensitive to the combination of penicillin and sulfonamides than to either drug alone. Either preparation may be used for prophylactic treatment in operative procedures in which secondary infections are likely to occur. Both products are supplied in 60 cc packages. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 751)**

Vascutol

Vascutol is a new and effective combination of lipotropic agents for use in the management of atherosclerosis and liver disease associated with lipid metabolism. The new liquid contains choline, inositol and pyridoxine in a pleasant, cherry-flavored syrup of high lipotropic concentration. It is supplied in 16 fluid ounce bottles. **Schenley Laboratories, Inc., Dept. MH, Lawrenceburg, Ind. (Key No. 752)**

White's Guaiatussin

White's Guaiatussin is a rationallly formulated, palatable cough syrup. It contains glyceryl guaiacolate, which has been shown to be an efficient and potent expectorant, and phenyltoloxamine, an effective antihistaminic and local anesthetic agent, in a highly palatable vehicle. It is supplied in 16 ounce and gallon bottles. **White Laboratories, Inc., Dept. MH, Kenilworth, N. J. (Key No. 753)**

(Continued on page 246)

Mycitracin Ointment

Mycitracin is a non-irritating and bland ointment containing the antibiotics neomycin and bacitracin. The antibacterial agents are suspended as finely divided particles in a base designed to preserve their stability and permit release at the point of application.

The new ointment is effective against both gram-positive and gram-negative organisms. It is relatively non-irritating and non-toxic to epithelial cells and does not interfere with wound healing. It is supplied in one-half ounce tubes. **The Upjohn Company, Dept. MH, Kalamazoo, Mich. (Key No. 754)**

Tyotocin

Tyotocin is a new antibacterial and antimycotic treatment for ear infections. Tyrothricin and hexylresorcinol, two agents in Tyotocin, possess antifungal and antibacterial properties. Relief from pain and itching is provided by antipyrine and benzocaine. Anhydrous propylene glycol and anhydrous glycerin provide hygroscopic activity. Tyotocin Ear Drops are supplied in ½ fluid ounce bottles with dropper. **Sharp & Dohme, Inc., Dept. MH, 640 N. Broad St., Philadelphia 1, Pa. (Key No. 755)**

What's New . . .

Product Literature

• A monthly entree recipe and suggested meal menu printed on a 4 by 6 inch card for convenient filing is offered in **Armour's "Quantity Recipe of the Month."** This is a new free recipe service offered by Armour and Company, Hotel and Institutions Dept., Chicago 9. The recipes have been tested by the Armour Consumer Service Department and are selected for their timeliness, low serving cost, ease of preparation and novelty. Ingredients are based on a yield of 50 servings. Each recipe includes an illustration of the finished serving. **(Key No. 756)**

• A gate fold page in the center of the new **Kewanee-Iron Fireman Catalog** illustrates the operation of the new **Boiler-Burner Unit** in full color. Cut-out sections in the illustration show the internal workings of the unit and each point is carefully discussed. Full data on ratings and dimensions are given on the other side of the enlarged page. The full line of Kewanee-Iron Fireman Boiler-Burner Units is described and illustrated in the full color catalog to aid in selection of the proper unit for any application. The catalog is available from Iron Fireman Mfg. Co., 3170 W. 106th St., Cleveland 11, Ohio, or Kewanee-Ross Corp., Kewanee, Ill. **(Key No. 757)**

• The new **Turkey Handbook** is now available in a revised edition. The 68 page booklet tells the story of the turkey, the "All-American bird," its use in institutions, including hospitals, quality designation, meaning of turkey labels, information on processed turkey, turkey portion costs, yields from various sizes of turkeys, how to prepare turkeys and turkey recipes. The section on hospitals includes a report on the use of turkeys, with charts on the results of studies at actual hospitals. The booklet is illustrated in black and white and in full color. One copy will be mailed free on request to National Turkey Federation, Dept. MH, Mount Morris, Ill. Additional copies are available at 35 cents each. **(Key No. 758)**

• Designed to provide recipes for hard-to-please patients, the new **Recipe Magic book** issued by H. J. Heinz Co., Home Economics Dept., Pittsburgh 30, Pa., features recipes using Heinz strained and junior foods. These between-meal nourishments include such taste-tempters and new ideas as an Apricot Flip, a Prune-Orange Shake and a Frosted Peach Whip. Also included are appetizing and nourishing suggestions for soups, salads, main dishes and desserts as well as beverages, all offering maximum nourishment with stimulating taste in appetizing form. **(Key No. 759)**

• **"Planning the X-Ray Processing Facilities and Equipment"** is the title of a new booklet designed to assist architects and hospital personnel in planning x-ray processing facilities and equipment. The booklet, available from the Medical X-Ray Sales Division, Eastman Kodak Co., Rochester 4, N. Y., covers planning the general layout, light-tight entrances, electric wiring, ventilation, floor and wall covering and illumination, the construction of the loading bench, x-ray processing tanks design, materials, installation and plumbing for x-ray processing tanks, and temperature control for x-ray processing tanks. **(Key No. 760)**

• Decorating ideas are offered in the new **1953 Kentile Catalog** recently released by Kentile, Inc., 58 Second Ave., Brooklyn 15, N. Y. Printed in full color, the catalog pictures numerous Kentile installations and illustrates Kentile patterns available. Information on the resiliency, comfort and safety underfoot, ease of installation and maintenance of Kentile is included. **(Key No. 761)**

• **Eclipse Type-D "Steamboilerplants"** are illustrated and described in a new catalog recently released by Eclipse Fuel Engineering Co., Rockford, Ill. Descriptive information and photographs are suplemented by line drawings showing the various plants. **(Key No. 762)**

(Continued on page 248)

What's New . . .

• A 48 page **Supplement to the Picker X-Ray Accessories Catalog** is now available from Picker X-Ray Corporation, 25 S. Broadway, White Plains, N. Y. The Supplement covers the many new items that have been introduced since release of the 200 page 14th edition of the Picker catalog. Included is information on the Picker-Polaroid Processing Unit which delivers a finished dry radiograph within one minute after exposure, the "Darex" Flexi-Cast immobilizing cast and other new items. **(Key No. 763)**

Book Announcements

Rhodes and Van Rooyen, "Textbook of Virology," 568 pp., $8. **The Williams & Wilkins Co., Dept. MH, Mt. Royal & Guilford Aves., Baltimore 2, Md. (Key No. 764)**

Martin "Hospital Accounting Principles and Practice," revised 2nd ed., 320 pp., $5.75. **Physicians' Record Co., Dept. MH, 161 W. Harrison St., Chicago 5. (Key No. 765)**

"American Pocket Medical Dictionary," 19th ed., 639 pp., $3.25 plain, $3.75 thumb-index. "Nursing in Diseases of the Eye, Ear, Nose and Throat," from the Manhattan Eye, Ear and Throat Hospital, 9th ed., 317 pp., $4. Bogert, "Fundamentals of Chemistry," 7th ed., 648 pp., $4.50. Davis and Strong, "Urological Nursing, "5th ed., 196 pp., $3.25. Muller and Dawes, "Introduction to Medical Science," 3rd ed., 610 pp., $4.75. Rattner, "Dermatology, A Textbook for Nurses," 270 pp., $4.25. Reinhardt, "Society and the Nursing Profession, An Introductory Sociolgy," 256 pp., $3.50. Conn, "1953 Current Therapy," 863 pp., $11. **W. B. Saunders Co., Dept. MH, W. Washington Square, Philadelphia 5, Pa. (Key No. 766)**

Suppliers' News

Merck & Co., Inc., Rahway, N. J., manufacturing chemists, announces that the principal terms of a merger between that company and **Sharp & Dohme, Incorporated, Philadelphia,** pharmaceutical manufacturers, have been approved. The name of the combined company will be **Merck & Co., Inc.** The distinct functions of each of the firms will be maintained, and the business of Sharp & Dohme will be continued under the Sharp & Dohme name, operating as much as possible as a decentralized unit under its present management.

Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn., manufacturer of floor maintenance equipment, announces purchase of the manufacturing facilities of the **Industrial Vacuum Cleaner Department** of the **General Electric Company.** A new factory is under construction in St. Paul, Minn., where the industrial line of vacuum cleaners will be produced.

Prometheus Electric Corp., 50 Webster Ave., New Rochelle, N. Y., manufacturer of hospital, medical and dental equipment, announces the appointment of **W. A. Bushman Associates, Inc., 1841 Broadway, New York 23,** as manufacturers' representative for the Prometheus line.

The following manufacturers have announced changes in address:

Arthur L. Peirson & Co., manufacturer of food products, from **189 Chrystie St., New York 2,** to **South End Blvd. and Montrose, Vineland, N. J.**

Refrigerated Equipment Sales Corp., manufacturer and distributor of refrigerators and similar equipment, from **19 W. 44th St., New York 18,** to **89 W. Broad St., Mount Vernon, N. Y.**

L. Sonneborn Sons, Inc., Building Products Division, to new and larger quarters at **404 Fourth Ave., New York 16.**

U. S. Industrial Chemicals, Inc., manufacturer of tax-free alcohol, from **60 E. 42nd St., New York 17,** to **120 Broadway, New York 5.**

The Visi-Shelf File, Inc., manufacturer of the Visi-Shelf filing system and laboratory and other cases, from **46 W. Broadway,** to **105 Chambers St., New York 7.**

Vogel-Peterson Co., Inc., manufacturer of wardrobe equipment, from **624 S. Michigan Ave., Chicago 5,** to **1127 W. 37th St., Chicago 9.**

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 713 Instrument Washer-Sterilizer
- ☐ 714 Vacuum Pump
- ☐ 715 Bell Cord and Tubing Holder
- ☐ 716 Plasticon Sheeting
- ☐ 717 Pictura Furniture Group
- ☐ 718 Bed End and Spring
- ☐ 719 Food Waste Disposer
- ☐ 720 All Purpose Terra-Tile
- ☐ 721 Reach-In Refrigerator
- ☐ 722 Vacuum Cleaner
- ☐ 723 Aluminum Fry Pans
- ☐ 724 Food Checking Machine
- ☐ 725 Mobile Clinic
- ☐ 726 Portable Food Cart
- ☐ 727 Surface Luminaire
- ☐ 728 Cellulose Napkins
- ☐ 729 Ice Maker
- ☐ 730 Microfilm Projector
- ☐ 731 "Space Saver" Dishwasher
- ☐ 732 Linen and Uniform Hamper
- ☐ 733 Tomac Wheel Stretcher
- ☐ 734 Two China Patterns
- ☐ 735 Stand-By Electric Plant
- ☐ 736 Medicone Series
- ☐ 737 Rotary Snow Plow
- ☐ 738 Plastic Brite Kit
- ☐ 739 Improved Electron Microscope
- ☐ 740 Reviewer 500 Projector
- ☐ 741 Stainless Steel Utility Tables
- ☐ 742 Floor Tester Kit
- ☐ 743 "Jet Flow" Sink
- ☐ 744 Fenestra-Nepco Electrifloor
- ☐ 745 Furniture Glides
- ☐ 746 Aerator-Mixer
- ☐ 747 Welsh Electrode
- ☐ 748 Automatic Sink Dishwasher
- ☐ 749 Waste Bag Holder
- ☐ 750 Distrycin
- ☐ 751 Suspension Neolin
- ☐ 752 Vascutol
- ☐ 753 White's Guaiatussin
- ☐ 754 Mycitracin Ointment
- ☐ 755 Tyotocin
- ☐ 756 Quantity Recipe Cards
- ☐ 757 Boiler-Burner Units
- ☐ 758 Turkey Handbook
- ☐ 759 Recipe Magic Book
- ☐ 760 X-Ray Processing Booklet
- ☐ 761 Kentile Catalog
- ☐ 762 Eclipse Catalog
- ☐ 763 X-Ray Accessories Catalog
- ☐ 764 "Textbook of Virology"
- ☐ 765 "Hospital Accounting"
- ☐ 766 Book Announcements

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Hall creamers are pure white inside and can be kept that way permanently with a minimum of cleaning and sterilizing. Made of heavy, fireproof china by an exclusive process, they are crazeproof, absorption-proof, and stainproof. Reasonable first cost and extreme durability make them the most economical creamers you can buy.

Write on company letterhead for Catalog 53 which lists almost 1,000 different Hall China items and contains a color chart of the 27 beautiful underglaze colors that are available.

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Hall Creamers are made in sizes ranging from individual to banquet service. Sugars are also available.

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FIREPROOF CHINA

in a Restaurant Operation today, you must have

A "QUALITIZED" ECONOMY!

Just as a trip can be ruined for want of a spare tire, the best Restaurant operation can't succeed today without the kind of economy that takes quality into consideration.

So-called "economizing" which cuts quality, drives away customers and thus makes overhead expenses harder to carry, is no economy at all. "Qualitized" economy *builds* volume by giving better value and finer eating goodness, while *reducing* preparation costs, spoilage losses, and food waste. These are often called "hidden losses."

Here's the kind of economy you get by using Gumpert Quality Food Specialties — a "qualitized" economy that's making money for over 40,000 Gumpert users. You're missing something if you don't ask your Gumpert Field Man to show you how easily *you* can have it!

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